

INDIAN HEALTH ISSUES GRAND FORKS, N. DAK.

HEARING
BEFORE THE
SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE
NINETY-EIGHTH CONGRESS
FIRST SESSION
ON
INDIAN HEALTH ISSUES

JUNE 2, 1983
GRAND FORKS, N. DAK.



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INDIAN HEALTH ISSUES

JUNE 2, 1983

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Grand Forks, N. Dak.

The committee met, pursuant to notice, at 10 a.m., in the Student Union Lecture Bowl, University of North Dakota, Grand Forks, N. Dak., Senator Mark Andrews (chairman) presiding.

Present: Senator Andrews.

Staff present: Paul Alexander, staff director.

Senator ANDREWS. The meeting will come to order. Ladies and gentlemen, I am happy to be here today to welcome you to this hearing of the Select Committee on Indian Affairs addressing Indian health issues.

I am pleased to note the presence of our host today, Dr. Tom Clifford. We thank you, sir, for providing us with these most comfortable accommodations. Many of you have been in Washington this year. Nearly as comfortable facilities down there in the Capitol City as we have right here in our own university. And I also have the pleasure of saying hello to Dr. Tom Johnson, the dean of the University of North Dakota Medical School. There are a lot more familiar faces out there, representatives of our Indian into medicine program and of our North Dakota tribes and even an occasional visitor that slipped over the border from Minnesota. Welcome to all of you.

The principal purpose of today's hearing is to receive testimony on the reauthorization of the Indian Health Care Improvement Act, Public Law 94-437. That act established a number of programs that benefit North Dakota tribes and tribal health organizations. Title I of the act authorizes a nationwide effort to recruit Indians into the health professions and we are proud to have in North Dakota one of the finest examples of that effort, the Indian into medicine program. We expect to hear testimony today from our friends at INMED and to learn specifically how that program is fairing in the context of diminished administration budget requests for Indian health manpower activities in fiscal year 1984.

As we begin the work of drafting a bill to reauthorize the Indian Health Care Improvement Act, it is especially important that those of us in Congress hear from the people who would be most affected by this pending legislation and to examine at the source the problems that reauthorization legislation is intended to remedy. So in addition to any specific discussions of the need to reauthorize the Indian Health Care Improvement Act, I hope that the tribal representatives we have here will tell us more about the health problems that are occurring on the reservations.

Are there enough doctors and nurses out there to provide the quality of health care to Indian people that other American citizens enjoy? Are the facilities and the equipment available adequate? Are there medical technicians and laboratories to process the blood tests and the X-rays? Do most reservation communities have access to health facilities or do tribal members have to travel great distances in rural areas to seek medical diagnosis and treatment? What effect will competitive bidding and proposed budget cuts have on existing resources? Will hospitals serving rural areas be forced to close?

The need for answers to these important questions has provided the impetus for committee hearings on issues of Indian and Alaska Native health around the country.

In late March the committee held a joint hearing on Indian health issues with the House Interior and Insular Affairs Committee in Phoenix, Ariz. My colleague on this committee, the senior Senator from Arizona, Barry Goldwater, was so moved by what he heard at that hearing that upon his return to Washington he wrote a long letter to the President, and sent a copy to me, reflecting his views as to the great importance of providing medical care and service to the Indian people and he said, and this is a direct quote:

I came away from the hearing more convinced than ever that there is tremendous neglect of the basic needs and necessities for our native Americans and I am talking about basic rights to such necessities as adequate medical care, education and shelter. These are not luxuries:

In his letter the Senator pointed out that we had an obligation and an opportunity in Indian affairs to set a standard for human rights here at home.

I agree. Health care is an extremely critical area for the United States to evidence its commitment to the tribes. What we do in this area affects everything. For example, a child's ability to learn and later function as a productive person in the community begins with healthy parents and proper prenatal care. We have made much progress in the last several decades, but much remains to be done and we must not abandon our commitments just as our efforts begin to bear fruit.

Our witnesses today have been scheduled in advance. Each witness will make a short presentation and then, of course, I will ask questions.

Let me point out that my personal feeling about the answers to those questions that I mentioned earlier in my opening remarks, of course, is no, we are not doing what we ought to be doing.

I am also well aware that under the agreements that the Federal Government had with the several tribes in this country during the first century of this Nation's existence, we agreed as a Nation to provide to tribes, in exchange for their tribal lands, health care, education, and housing in perpetuity direct from the Federal Government to the sovereign Indian tribes and it is not a matter of somebody's whim and later legislative, shall we say, fancy. It is something that is basic in our Constitution and it is something that is basic in the agreements that our Nation has made with those tribal governments. That is why we are addressing it today and I have directed the committee not only to hold this hearing which I am going to chair personally, but we are also sending two members of our staff into Alaska tomorrow to conduct hearings up there that Senator Murkowski will participate in,

and Paul Alexander, staff director of the Indian Affairs Committee will conduct a hearing in the State of Washington next week.

The reason for all of this is that we have to gather the evidence to make the case because, as you know, many of these programs have been zeroed out in the budget process and the only way we can put these programs back in is to get the information that will justify the programs not as government spending programs but as investments.

I do not care how you draw it. If you do not address the INMED type program, it is going to cost you a whale of a lot more later on.

In the field of nutrition, for instance, I had the president of Tufts University come testify on the WIC program, a program for nutrition of pregnant women, before another subcommittee on human nutrition, the Appropriations Committee on Agriculture. John Meier, who is one of the leading nutritionists, a former French resistance fighter, and now the president of Tufts University, came in very strong and said:

Look! If you do not give a damn about people and all you think about is dollars, then this is a wise investment because every dollar you invest here saves \$4 on down the line.

I totally agree with him. In this day of MX missilery and all the rest, when we are talking about world dominance and trying to lead, if this Nation does not have a heart, how can we tell everybody in the troubled world who has a head that we are not going to honor some of our oldest negotiations, our oldest agreements that were made with the several tribes around this country.

That is why we are trying to get this basic information on the record and that is why it is a privilege for me to bring this hearing of the committee out to my own State where I think we have some of the most perceptive individuals, in this field anyway.

The first witness is Dr. Tom Clifford, the president of the University of North Dakota. Tom, if you will come up.

I can assure the witnesses that your remarks will appear in the record as if uttered. If you have prepared remarks you can summarize them and then we will have the opportunity for questions. If you do not have prepared remarks, then you can proceed in whatever manner you might wish.

Tom, welcome to the committee. We are anxious to hear what you have to say.

STATEMENT OF DR. TOM CLIFFORD, PRESIDENT, UNIVERSITY OF NORTH DAKOTA

Dr. CLIFFORD. Thank you very much, Senator. My name is Tom Clifford. I am president of the University of North Dakota.

I do not have prepared remarks, but I am prepared to speak and I welcome this opportunity because I think the INMED program is a very important program and one that I am very delighted to have you come out here and visit. We have had a long history of that program on this campus.

We have been in the INMED business for about 10 years and I have watched the program from its inception. I watched it develop

and I have watched the people that have worked in it visit with the students. I have talked with the advisory committee when they were here on the campus, and I have talked with the people in the medical school and our health centers, so I have some idea of what the impact has been on the individuals that have been participants in this program. I have also visited with the staff from time to time so I have an idea of their perceptions and also what their evaluation is regarding the success of the program.

Later on you are going to get a lot of statistics about the number of people that are in there and the different disciplines in medicine, nursing, medical technology, and so on, so I am not going to be redundant about that. Rather I am going to talk to you about my own perception of the worth of the program itself.

First, it is impressive to me that the INMED program has attracted and created a lot of interest on the part of the Indian students on the reservations and in the cities to come into these careers, when students have had no possible aspiration for this before. It has opened up pathways that simply did not exist 10 years ago and these pathways have been followed. They have brought in a great many people to participate in the programs at the college level. They have given them the support that is necessary to do the courses well and to prepare themselves adequately so that when they get into a program they are adequately trained to participate in that program like any other person. I think that is enormously important.

The medical school here left so many slots for people that wanted to be in medicine to come through the INMED program that they insist that those qualifications be as good as any other applicant that we have in the program. I think that is extremely important because, for one thing it is a matter of pride. The people going into it need to know that they are as well equipped as anyone else. The INMED program has had a great hand in preparing Indian students so they can reach the level of efficiency that they needed to have to do these programs well.

I have visited with a number of students and talked to them about how they happened to get into the program. One thing they said was that many of them had aspired to pursue a health care education for a long time. They just did not think it would be possible. As they worked their way through the educational system they felt that perhaps some day it might happen, but they did not have an idea that they could have something like INMED come along and help them attain the goal that they have had all of their lives. They feel deeply about that.

They feel keenly about that. They also feel keenly about going back and sharing some of their talents and some of their training with the people, the other Indian people. They have a loyalty, I think, that is very, very important. They feel that they have something to give. That talent that they have is being developed and then they are sharing it. I believe that attitude is extremely important in their success.

There have been some rough spots. There have been times when it has been difficult for the people in selection. It has been difficult to outline the procedures for training them, but the staff of INMED have done a tremendous job.

No. 1, they have always kept touch with the people that they are serving. They have a regional advisory committee that they bring in here. They listen to that advisory committee. As a result of that, they have modified many of their procedures, but through it all, from the early directors right down to our current director, Dr. Lois Steele, they have the excellence of those individuals. They have really been very careful about that. That is one of the reasons this program has been successful.

We visit with people from reservations in North Dakota. Those are the people with whom I am really most familiar. We find that there is a tremendous health program on most of the reservations and this to me seems to be a logical way of approaching the solution to some of these health problems. People that are coming out and are being trained know the situations on the reservations. They know the situation in the cities of the State and they know the problems that the native American people have. They are compassionate; they are sympathetic for them. As a consequence, they are going to do their best to alleviate those health problems.

So to sum it all up, as I look at it, the goals and expectations and aspirations of this program as they were outlined 10 years ago have been developing and are largely met. I think that they are coming to that, but we are right on the threshold of it.

The numbers of doctors that we have trained and that have been admitted to medical programs, probably far exceed the number of native American doctors that have become qualified to practice since 1973. From the sense of the quantitative, the program has been successful, but I also think that the quality of program that I talked about earlier is equally important and that has to continue so that we have a certain threshold that is obtained.

They have a certain momentum. They have developed a lot of procedures. They have developed a lot of knowhow. To me, to withdraw a program of this kind at this time would be very detrimental to the native American people and I think it could be detrimental to us as a nation.

We feel that they are just starting to do the thing well. Ten years is a relatively short time in an educational cycle and 10 years is a very short time to talk about raising the aspirations of the people on the reservation so they can get into this program. Right now they are out there, whole classes of people that know about this. They are counting on it and they want to go ahead and do what has been done before and I think they will do it very well.

I notice that in the statistics from the reservations in this area that before the very first ones we didn't have a lot of people from the North Dakota reservations or even from South Dakota for that matter, but now they are coming from those reservations. I think that buttresses what I said about their really being aware of what is going on. They are preparing themselves, and with that kind of a goal ahead of them, they really work hard, so I am totally in support of this.

The people who we have running the program are good. The way they bring the people from the reservation in to get the advice on it is excellent. I have been in the committees and there are very perceptive remarks from the people who are advisers. It is a good system and we should keep it.

Senator ANDREWS. Actually, Mr. President, then what you are telling us is that on the 10th anniversary of the program, as you look back on a decade of this program you are finding that the applicants are better trained because they have been able to anticipate the fact that the program is here and in their preparatory work in high school and undergraduate work they have been able to prepare themselves for a program because they have known it is there.

Dr. CLIFFORD. They have that aspiration, yes.

Senator ANDREWS. And you are finding in the last 3 or 4 years that you have a bigger pool of applicants to draw from, a better qualified pool of applicants.

Dr. CLIFFORD. Yes, sir. I think that is true. It is true for a lot of reasons.

Of course, there has been a lot of effort in other sectors to improve teaching on the reservation. They have had many, many teachers and the teacher corps, and all of those things have been working out there to develop teachers on the reservation. I think the whole level of instruction on the reservations, at least around here, has improved. But I think mostly it has been the fact that those students out there have had something to go for.

Senator ANDREWS. They have had a goal.

Dr. CLIFFORD. They have.

Senator ANDREWS. And that young man and woman of elementary and high school age has been able to set their sights on this program that they knew about and they have been able to guide their life toward that goal and that is something that is extremely important as well.

Dr. CLIFFORD. That is right.

And by the same token, to cut that program off abruptly would send tremendous shock waves of frustration all the way back through that system.

Senator ANDREWS. You see, one of the problems that we face in this, is that the Office of Management and Budget look at the overall national statistics and they find that we have too many doctors today. Now that is not true on the Indian reservations and that is not true in rural counties in a State like North Dakota. You and I know that and what we have to do is move those statistics back so people understand where we are totally underserved.

In your experience as president of the university, do you find that the Indian student has a desire not just to become a doctor, but to become a doctor uniquely to go back and live on the reservation and be with his and her people as well?

Dr. CLIFFORD. Many of them do. That is the loyalty that I alluded to earlier.

There is a strong loyalty to the people on the reservation. They have a real bond and many of those people are interested in returning to the reservation and I think that as you attract more students, more Indian students that were raised on the reservation, that bond is even stronger.

You see, some of our applicants initially have Indian ancestry but were not from the reservation. I do not know whether they had that same kind of loyalty or not. I do not know.

But I do know that the ones they are getting now, the ones that are coming out of school now have had that connection and I think it just stands to reason that they have that deeper feeling.

I know it is true in our paramedic program because they have that kind of feeling. They talk about going back to Rosebud and they mention that to me personally, but I am sure that is true of the doctors also.

Senator ANDREWS. Very good. Thank you very much, Mr. President.

The second witness is Dr. Tom Johnson, dean of the University of North Dakota Medical School. Tom, do you want to have the rest of the INMED people with you or do you want to go on when we get the INMED people up as a group afterwards?

Dr. JOHNSON. I think it would be better as a group afterwards.

Senator ANDREWS. OK. That is what I was thinking. You have a prepared statement. Let me assure you it will be printed in the record in its entirety if you want to summarize it.

STATEMENT OF DR. TOM JOHNSON, DEAN, UNIVERSITY OF NORTH DAKOTA MEDICAL SCHOOL

Dr. JOHNSON. Thank you very much, Senator Andrews. My name is Tom Johnson. I am the dean of the University of North Dakota School of Medicine and I appreciate this opportunity to appear before you to discuss the issue of the Indians in the medicine program.

This program is an integral part of the school of medicine. Dr. Lois Steele, its director, is a member of my staff and therefore sits on all dean's council meetings and participates in all administrative decisions in the school of medicine. Their offices are an integral part of the medical school located in our north unit along with our clinical departments and other administrative offices.

We are very proud of INMED's achievements. The University of North Dakota School of Medicine is the only medical school in the country that has added five spots specifically for native Americans. The program at this date has graduated 32 physicians. There are 19 more in medical school and we are proud to say—and this supports President Clifford's remarks—that instead of five, eight students will be admitted to medical school this fall; five to the University of North Dakota, one to Stanford, one to the University of Washington, and one to the University of Minnesota-Duluth.

Now as President Clifford also said, I believe very strongly that one of the most important components of this program is its university and preuniversity programs for the support of the students. Each summer about 50 to 60 promising students from the reservations attend 5 weeks of classes here to upgrade their skills, especially in the sciences and those that are admitted to the university as undergraduates are then, through INMED, provided important support systems so that they will be able to make the course and be admitted to medical school. I think that the success is shown by the fact that there were eight of them this year.

Now, not only does this program here have an influence on the students, it is also having an influence on the school of medicine and

we are becoming more and more responsive, we believe, and hope to become more responsive to the special needs of the native American population in this region.

For example, in the past year, under the leadership of the INMED program, we conducted a surgical program in Belcourt that was initially successful and an o.b.-gyn program at Fort Yates. And, it should be noted that while our faculty member was onsite at Fort Yates there were no obstetrics or neonatal deaths during that period of time.

It is my feeling that the need for improved health care for native Americans is painfully evident and we are trying to respond to those needs. We are having a meeting later this afternoon with the officials in the Indian Health Service to discuss this.

Although our primary purpose is to provide quality education for our students, we believe our greatest contribution can be made by educating students and continuing our commitment to educate native American students with programs that provide special support services to them.

The shortages of physicians in rural areas has been spoken to, but there is no more critical shortage of physicians and other health care personnel than on Indian reservations and especially in this region. This is from my personal observations. I believe that health care on the reservations that I visited is one of the outstanding unmet needs of our society and that the records do show that those who come from reservations trained in this program return. Nine of the first twelve graduates have returned to work with their people and they are the most valuable type of practitioner because they not only are competent but they understand the needs and laws of native Americans.

One critical area that I would like to speak to is the student financial situation for all medical students but especially the barrier that has been placed in the way of minorities and especially our Indian students. We believe it is important to preserve service pay back scholarships that are part of the Indian Health Care Improvement Act. As you know, these students must serve in return for paying for their education and it really is a cost benefit compared to the salaries paid in private practice as well as the saving in recruitment costs. The University of North Dakota School of Medicine respectfully requests that full funding be continued to the INMED program, and that adequate funds be committed to the 62 allocated scholarships.

Both President Clifford and I have talked about the success of INMED, but I would like to note for the record the accomplishments of two specific people. The first is a 1983 INMED University of North Dakota graduate who went through the full program here at the university, Dr. Lewis Gilbert. Lewis Gilbert is a member of the Gros Ventre Tribe from Montana and during his first 2 years in school, he compiled an almost perfect record on part I of the National Boards but more importantly he won the 1983 Kaiser Award for the outstanding minority medical student in the United States.

The second is a person to whom I want to personally give credit. She is a very special person who is really giving her life to making INMED work. She is the director, Dr. Lois Steele, who is an exceptional person and I would like to state that without her the program would not have happened—she was the first director—nor would the

program be as viable and productive as it is today. The staff that she has selected is an outstanding group.

In closing I would like to assure the committee that the University of North Dakota School of Medicine is committed to continuing this most important program, not only for the opportunity it gives to physicians but also for the benefit of promise it provides in improving health care for a population that I firmly believe has a true and desperate need. Thank you very much.

Senator ANDREWS. Thank you very much, Dean.

You mentioned that 9 of the first 12 graduates returned to work on the reservation. Are those the only graduates?

Dr. JOHNSON. No. There were 32 graduates.

Senator ANDREWS. And those are not through your residency program so what you have is three quarters of those people who have completed their full cycle of training have gone back.

Dr. JOHNSON. That is right.

Senator ANDREWS. Would you anticipate that about that percentage will continue to return to the reservation?

Dr. JOHNSON. President Clifford stated that there was a period of time that we had recruited students from other places in the United States, not from reservations. We do not know their commitment, but those that have been recruited from the reservations have had good records.

Senator ANDREWS. Two years ago, Doctor, I personally offered an amendment to provide for the fiscal year 1982 scholarship to a particular student to be reobligated to another student should the original grantee not continue in the program, so that those moneys would not have to be returned to the general treasury. Has this amendment been put into effect in any case of which you are aware?

Dr. JOHNSON. I do not have the answer to that, Senator.

Senator ANDREWS. What would happen to the students currently served by the INMED program if funding for the program was eliminated?

Mr. JOHNSON. I think that would be a disaster. The students are unable to support themselves. They are unable to pay for the tuition. Also, the program has been a federally funded program and that is an important component of it. I believe that the end of the program right at this point with the amount of funds and work that has been put into it would be like General Motors shutting down the Chevrolet line after the first 100 automobiles.

Senator ANDREWS. In your opinion, do you feel that what Doctor Clifford said was essentially true; that these students are not just minority groups going through, but they are actually adding to the overall breadth of the medical school, that they are competent physicians when they graduate and that they are going to do a great job wherever they may practice their profession?

Dr. JOHNSON. Yes, sir. We will make sure of that.

Senator ANDREWS. They are just as good as any other students. In fact it looks as though one of them was a lot better than most.

Dr. JOHNSON. And we have had more than just one.

Senator ANDREWS. Great. Well, that is an outstanding record of achievement. Thank you, doctor.

[Dr. Johnson's prepared statement follows:]

PREPARED STATEMENT OF DR. TOM JOHNSON, DEAN, UNIVERSITY OF NORTH DAKOTA
SCHOOL OF MEDICINE

My name is Tom M. Johnson, and I am the Dean of the University of North Dakota School of Medicine. Thank you for allowing me to appear before you to discuss the School's program known as Indians Into Medicine or InMed. Since its inception ten years ago, the InMed Program has been an integral part of the School of Medicine. Its director, Dr. Lois Steele is a member of my Dean's Staff. She therefore sits on the Dean's Council Meetings as well as all meetings with Department Chairmen of the School of Medicine. InMed's offices are located in the Medical School's North Unit, along with our Administrative Offices, clinical departments, and other programs of the School of Medicine.

We are very proud of InMeds achievements. The University of North Dakota School of Medicine is the only medical school in the nation which has added five slots to our entering freshman class specifically for Native Americans. The InMed Program has graduated thirty-two physicians as of this date. Nineteen Native American students associated with the program are in medical school, and eight more have been admitted to medical school this fall; five to the University of North Dakota, one at Stanford, one at the University of Minnesota-Duluth, and one at the University of Washington.

In my opinion, one of the key elements to InMed's success is the very active University and pre-university programs which are fundamental components of the InMed Program. Each summer, promising Native Americans students, yet in high school, are recruited to the University of North Dakota from reservations to attend five weeks of college preparatory courses in science to upgrade their skills. In the second component, Native American students admitted to undergraduate studies at the University of North Dakota with a pre-med major are provided an active support system through InMed such as peer support, tutoring, study aides, and academic counseling. Although it is not easy to be admitted to medical school, I believe that the eight new Indian students admitted this year are indicative of the success of the program in preparing undergraduate students for pre-medical courses, the admissions process, and ultimately the challenges of medical school and medical practice.

In addition to its direct influence on Indian students, the InMed program has begun to have a positive impact on the School's responsiveness to the special needs of the Native American population in this region. For example, the faculty members in the Department of Surgery under the leadership of their Chairman, Dr. Edwin James, are presently working with the Indian Health Service in a program to meet the needs of Native Americans in North Dakota for adequate surgical services. We feel that this effort is progressing well, taking place over the past year at Belcourt. Initially successful efforts to assist the Obstetrics and Gynecology services occurred last year at Ft. Yates. While our faculty member was on site there were no obstetrical complications nor were there any neonatal deaths. The need for improved health care for Native Americans is painfully evident and the School of Medicine is committed to its role in responding to that need. We are having a meeting later this afternoon with Officials from the Indian Health Service to determine if there are other ways that we can cooperate in meeting the health service needs, along with our obligation to provide quality education for our students. Our greatest contribution is through the education of future physicians and our commitment to educate Native American students and to provide special support services for them. Our cooperation in health service delivery is based upon mutual participation and equitable cost sharing among the various sectors involved in such endeavors.

The shortage of physicians in rural areas such as North Dakota is often overlooked by people in more heavily populated locations that have an adequate number of physicians. There is nowhere in rural America where there is a more critical shortage of physicians and other health care providers than on Indian Reservations, especially in this region. The constant turnover in temporary physicians coupled with this critical shortage makes health care on the reservation one of the outstanding unmet needs in our society. We at the School of Medicine believe that the InMed Program is a key to meeting the needs for physicians and health care in this region in the future. Our records show that most Native American physicians from reservations indeed finish residency training and return to take care of their people. It should be pointed out that nine of our first twelve graduates returned to work with their people. They are the

most valuable resource because they are competent practitioners of medicine, and because they understand the needs and lives of Native Americans.

Our critical problem area is the financial aid situation for all medical students. The reduction in financial aid places barriers to education particularly for minorities and especially for our Indian students. We believe it is important to preserve the Service Pay Back Scholarships that are a part of the Indian Health Care Improvement Act. The students that accept these must serve the Indian Health Service in return for the money paid toward their education. We believe this is cost effective in light of the salaries paid to physicians by the Indian Health Service versus the typical income of private physicians as well as the savings in recruitment costs incurred when the Indian Health Service must seek physicians from the general pool of graduates. The University of North Dakota School of Medicine respectfully requests that full funding be continued to the InMed Program and that adequate funds be committed to the sixty-two allocated scholarships.

We have talked of the success of InMed—I would like to note for the record the accomplishments of two people. The first is a 1983 InMed University of North Dakota graduate, Dr. Louis Gilbert. Louis, a member of the Gros Ventre Tribe from Montana, compiled a near perfect score on Part I of the National Boards and this year was given the Kaiser Award for being the outstanding minority medical student in the United States. The second is a very special person who has given her life to making InMed work. The Director, Dr. Lois Steele, is an exceptional person, and it should be stated that without her the Program would not have happened nor would it be as viable and productive as it is today.

In closing I would like to assure the Committee that the University of North Dakota School of Medicine is committed to continuing this most important program, not only for the opportunity it offers for Native Americans to become physicians but also for the benefit and promise it provides in improving health care for a population, that I firmly believe has a true and desperate need.

Senator ANDREWS. The next witnesses are Dr. John Vennes and Dr. Paul Ray from the medical school. We also have Art Raymond, the director of Indian programs; Jim Claymore, the INMED advisory board chairman; Elizabeth Demaray, the assistant director; Manny King, Kerry Hartman, and Lewis Gilbert, who was mentioned earlier so favorably as the winner of the 1983 Kaiser Award, and Emory Keoke with Joe Luger and Rodney Larsen who are all medical students and Tom Bellinger who is an INMED medical student.

Dr. VENNES. Thank you.

Senator ANDREWS. John, we have your statement. Let me assure you it will be inserted into the record in its entirety. Summarize it in any way you wish.

STATEMENT OF DR. JOHN VENNES, CHAIRMAN, DEPARTMENT OF MICROBIOLOGY AND IMMUNOLOGY, UNIVERSITY OF NORTH DAKOTA MEDICAL SCHOOL

Dr. VENNES. Thank you, Senator Andrews. My name is John Vennes. I am professor and chairman of the department of microbiology and immunology in the school of medicine and my comments this morning will be given to you as a faculty member who, over the past 10 years has been involved with the INMED program from its formative stages to its present stage.

I would like to speak about three things. The first is the guiding principles that evolved during the formative stages of INMED. I think they are important because they are an example of where a program such as this needs to have good principles established very early.

The first—and it has been spoken to much earlier—is the dedication of five slots in the school of medicine to entering students, in this case, American Indians. The second is that the program had personal and family support, a must for this program.

The third is that a collaborative model was established very early with the 5-State, 22-reservation, INMED advisory board. For those of us involved as faculty members on the campus of a small university over the past 10 years it has been very informative and very important to this program.

Senator ANDREWS. John, why five slots? Are there not some years when six or seven would be better, and some years when three would be adequate? Why the arbitrary five? Is it because of the space available in the entering class?

Dr. VENNES. I think it was felt that to make an impact five was a good number.

If you actually used the numbers in North Dakota, if we have 15,000 Indians in this State and if there are over 1 million Indians in this country, we really would only offer 1 slot based on that ratio. But in order to make an impact, in order to have a critical match of individuals, five turned out to be a good number.

The fourth guiding principle was the need for the development of an undergraduate premedicine program. That has been spoken to earlier by both President Clifford and Dean Johnson. And the fifth one is that we would accept ethnic but not academic minorities and the program has been sustained in terms of that guiding principle.

The second thing I would like to speak to is the role of the on-campus advisory committee. We have heard comments about the need for the 22-reservation advisory committee, but the INMED program is a professional program within the school of medicine and I would like to make just a couple of points concerning the on-campus advisory committee.

At the moment two of its members are here, Dr. Paul Ray sitting next to me, professor of biochemistry, and Dr. Bill Goodall who is the dean for clinical affairs in the school of medicine. The most important functions of the advisory committee are to be an advocate for the program and to establish the program as a credible program within the faculty of the medical school.

At least in the past, there was concern at faculty meetings about whether we really needed this kind of a program and the establishment of this advisory committee to carry out those two functions as an advocate and to establish the program's credibility with the faculty, I think, has been very important to the sustaining of the program.

A third important function is that the advisory committee acts in a problem solution role to the INMED director.

The next point I would like to make concerns the role of the university. The University of North Dakota was dedicated to the guiding principles that were established in 1973 for this program. Second, the institution has always made resources available to the program and third, the institution has been an advocate for the program.

But enough of the past, if I may quote Thomas Jefferson. He said, "I like the dreams of the future better than the history of the past," and Dr. William Osler, the father of medicine in this country, said, "Life is change, and happy are those who can change with it."

I have a few points to make concerning INMED's future. The first is that it needs continued fiscal support. There is very little doubt that the education of a physician in this country is expensive and it is even more expensive if you add the guiding principles that we alluded to just a bit earlier to support the students.

The second point is that INMED needs to be involved more in the continuum of medical education beyond the physician and we believe that it should be involved more with the Indian Health Service and particularly in the area of continuing medical education.

The third is that a program such as INMED, like any other program that has been around for a decade, needs both internal and external evaluation to determine whether it needs new guiding principles and new or renewed activity.

I would like to summarize my report by saying: No. 1, it has been for me, a native of North Dakota, a privilege to have been involved with INMED for the past decade. I believe that it has addressed the health care needs of American Indians. I believe that it has demonstrated that the collaborative model works and it also has demonstrated that a university in acting out its social conscience has assisted in the resolution of a social issue. Thank you.

Senator ANDREWS. Doctor, has any other medical school developed a program like the INMED program at the University of North Dakota?

Dr. VENNES. My information is that a number of medical schools have a minority officer who may or may not function out of the office of the dean, but I am not aware of a program that is as expansive as this program.

Senator ANDREWS. Those are not specific programs for native Americans like INMED, are they? They include minorities and they have a minority officer who looks at the applications, but they have no structured program such as this?

Dr. VENNES. Not that I am aware of. I am sure that you are aware, Senator, that several years ago there was an attempt to establish an American Indian medical school.

Senator ANDREWS. That is right.

Dr. VENNES. One need not look at the statistics too deeply to find out that if they had 50 graduating students over a 5-year period that that school would need to destruct and that that is not the answer to producing American physicians, either, because it would overproduce very quickly.

Senator ANDREWS. Dr. Ray, do you have anything to add?

[Dr. Vennes' prepared statement follows:]

PREPARED STATEMENT OF DR. JOHN VENNES, CHAIRMAN, DEPARTMENT OF MICROBIOLOGY AND IMMUNOLOGY, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE

My name is John Vennes. I am presently Professor and Chairman in the Departments of Microbiology and Immunology, University of North Dakota School of Medicine.

My associations with the Indians into Medicine (INMED) program at the School of Medicine extends over the last decade. During the formative stages of the program I was Acting Dean in the School of Medicine. Although the concept for INMED arose in the Department of Community Medicine, it was moved to a more visible position where the director, then Lois Steele, reported directly to the Dean of the School of Medicine. Also during that period, Dr. Paul Ray, Professor of Biochemistry assumed the position of faculty advisor to the program.

The early guiding principles for INMED were that (1) five dedicated positions would be made available to selected American Indians in the entering medical school freshman classes, (2) personal and family support would be a necessity for attracting qualified individuals to the program, (3) a collaborative model would need to be utilized—a twenty two reservation advisory board representing the five states of North Dakota, South Dakota, Montana, Wyoming, and Nebraska was established, (4) undergraduate, pre-medicine programs would be required on-campus in order to attract and retain qualified individuals in the program, and (5) although INMED was envisaged as an ethnic minority program it would not allow individuals with academic minorities into the program. All of these guiding principles remain integral to the INMED program.

After leaving the position of Acting Dean in 1975, I and Dr. Paul Ray became the on-campus Advisory Committee for the INMED program. We worked very closely with the INMED director (either Mr. Bernard Kahrahrah or Dr. Lois Steele), the Dean for Student Affairs (Dr. Wallace Nelson and later Dr. Nancy Furstenburg), and periodically met with the Deans (Dr. Richard Davis, Dr. Neil Thomford, and for the past six years Dr. Tom Johnson). My perception of the role played by the Advisory Committee was one of advocacy for INMED, problem solution with its Director, and assisting in maintaining credibility for the program within the Faculty. These roles were often in the category of resolving academic process problems but also related to the Strategic Planning and Administrative Control aspects of the program.

You will or have heard presentations by President Thomas Clifford and Dean Tom Johnson. Their dedication to the guiding principles alluded to earlier by making the resources of the institution available to INMED and by demonstrating program advocacy have been paramount in maintaining the viability of INMED. Without this display of institutional commitment INMED would have had a short tenure at the University of North Dakota.

But Thomas Jefferson said, "I like the dreams of the future better than the history of the past", and Dr. William Oser said, "Life is change and happy are those who can change with it."

INMED needs to look to the future and also may need to change. It needs continued fiscal support for an expensive educational experience for those American Indians who are selected to enter Medical School. It needs to become more involved in the continuum of medical education, not just the graduation of individuals with medical degrees. Placement of medical school graduates in residency programs and finally in practice settings which are important to American Indians must become future guiding principles for the program. And finally, INMED should consider more involvement with the Indian Health Service particularly in the area of continuing education. Already many of the graduates of the INMED program return periodically to campus for symposia and workshops. More emphasis is needed in this area.

And the program may need to change some of its other activities. These changes should occur only after both an internal and external evaluation of the program has been carried out. New or renewed guiding principles may emerge as a result of these evaluations.

I consider it a privilege to have been associated over the past decade with the INMED program—a program which addressed the needs of American Indians in the area of health and health education, which demonstrated that the collaborative model can effectively address social issues, and a University which was willing to act out its social conscience in assisting resolution of a prominent social issue.

STATEMENT OF DR. PAUL RAY, PROFESSOR OF BIOCHEMISTRY, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE

Dr. RAY. My name is Dr. Paul Ray. I am a professor of biochemistry here and I have no prepared remarks. I would like to say a few things, however, on behalf of INMED.

I have been associated with INMED nearly throughout its lifetime here. My role as a member of the advisory committee to INMED is similar to that which has been described by Dr. Vennes.

Consistent with Dr. Vennes and I working together, we discussed his testimony that he had just given and I had some input into his remarks and so I really have nothing to add to that, but I do want to affirm strongly the testimony given by him and by the others here and I want to emphasize that I consider it both a challenge and certainly a pleasure to have worked with INMED over the last 10 years.

Senator ANDREWS. Doctor, in your working with the program for 10 years, have you found, more and more, that you and/or people like you are passing information out to the reservations so that they, too, get an idea early on that this program is available and they can begin structuring their education in high school and early college?

Dr. RAY. Well, I think we do that in several ways. I think one of the best ways we can do it is by working with the INMED staff and of course preparing medical students who will be going back to their reservations and other reservations around this State and other areas of the country and who will be telling their people first hand about the experiences that they have gotten here.

I think the other way that we can disseminate information is by bringing high school youngsters here in the summertime and working with them directly, or working with Dr. Steele and the rest of the staff, to establish the programs that they are exposed to while they are here.

Senator ANDREWS. How many students do you have in an average summer program?

Dr. RAY. Oh, I would say maybe on the average of 40. I am sure that Dr. Steele will provide you with the exact statistics. It has varied, of course, depending upon the funding available, but I would guess an average of something like 40.

Senator ANDREWS. And those are the future applicants to be, so to speak.

Dr. RAY. That is the way we see many of them, yes, sir.

Senator ANDREWS. Thank you very much, both of you. I appreciate it. The next witness is Art Raymond.

My association with Art Raymond goes back many, many years. He is a fellow churchman and fellow political type and just a little bit known as a maverick from time to time. My reputation as a maverick should probably be included in this whole thing because this is a chain of events where we are fighting the administration of the Office of Management and Budget, but it is one of these things that we think is highly necessary and has to be done. Good to be doing business with my maverick friend again. Ray?

STATEMENT OF ARTHUR RAYMOND, DIRECTOR OF INDIAN PROGRAM DEVELOPMENT, UNIVERSITY OF NORTH DAKOTA

Mr. RAYMOND. Thank you, Senator Andrews. I am glad you brought out the tag of being a maverick.

I have no prepared remarks. I have come here this morning, Senator, prepared to talk about the INMED program but all of my predecessors in this chair have done that and done it well. Let me just say that that I reiterate and echo everything they have said.

You asked a question, sir, a few minutes ago and it was somewhat of a statement also saying that there are too many doctors. That well may be true, Senator Andrews, across the country, but there are certainly not too many doctors in the Indian Health Service working on the reservations with our people.

I am reminded somewhat of the time when Lawrence of Arabia first moved into Arabia to meet with the sheiks and the princes there to try to weld them together and he was talking with one of the sheiks and the sheik was telling him how much they were doing in the battle against the Turks in World War I and Lawrence of Arabia said, "Yes. But you're a long way from Damascus."

Senator ANDREWS. That is true.

Mr. RAYMOND. That is where we are today.

Senator ANDREWS. Art, I am sure you know that what I was saying, was that the statistics they are using that try to show an adequate supply of physicians are statistics that simply do not apply to Indian reservations or to rural counties in North Dakota. We know there is a severe doctor shortage in those areas.

Art, I would like you to address the fact that an Indian doctor going back to work among Indian people finds that those patients feel it a little bit easier to come in to talk to him or her because they are of the tribe, and because they are native Americans. In your opinion, could we probably, through the confidence that those patients have in an Indian doctor, see these patients a little bit earlier and do a lot more in preventive medicine work than we could if there were a lack of understanding or a lack of rapport that might exist with a non-Indian doctor?

Mr. RAYMOND. Yes, sir. I would be more than happy to do that.

I do not know how many of you know. I always label myself as a Sioux. My father was Oglala Sioux; my mother was Santee. I was born and raised in South Dakota and I am an enrolled member of the Rosebud Sioux Tribe. I was adopted by the Unkpapa Sioux on the Standing Rock Reservation and I work in the Indian field here in North Dakota so about all I can say is I am Sioux and I work with all of these people and I have a wonderful boss, the president of this university, Dr. Tom Clifford, who gives me the freedom to go around and to do the things I have to do.

We have seen, through the years, a critical shortage of native Americans, of doctors, of MD's and medical personnel in the Indian Health Service on all of these reservations because the personnel who come in from Connecticut, New Hampshire, Delaware or somewhere else do not stay. They do not like it here or their spouses do not like it here. Who would want to practice at Fort Totten, N. Dak., for example, when they could be practicing in Chicago and earning all of that money with all of the cultural benefits available to them. Why would they want to live at Rosebud, S. Dak., my home, when they could live down there?

Now I happen to like it there. I happen to love that place. That was where I was born and raised. But these doctors and their spouses coming in do not love those places.

So we have an aching doctor shortage at Fort Yates, N. Dak., where a doctor comes in once a week mind you. They have contract services

at the Crow Creek Reservation where the money has fallen short, Senator Andrews, and so they cannot come in at all. They desperately need a new hospital at the Pine Ridge Reservation.

The answer, sir, is not a cut back, but to build up such programs as these because these are the men and the women who are going to go to in there and stay because that is where they were born and raised. That is where they live. Those are the people they love and that is where they belong and that is why they stay there.

Senator ANDREWS. And, Art, when you visit with these students, whether they are Sioux or Chippewa or whichever tribe they belong to, you are finding that deep-seated desire to go back to the reservation and work among their people?

Mr. RAYMOND. It is a commitment we cannot ask but it is a commitment they give.

Senator ANDREWS. My grandmother and grandfather were both doctors. My grandmother was probably one of the first women medical students in the University of Michigan; graduated in 1877, went to New York City and practiced for a couple of years. I am sure ERA and women probably were not too recognized in New York City 100 years ago. Then they came out to Dakota Territory and started practicing medicine at a little stop on the railroad called Mapleton. They set up a drugstore 10 years before this became a State and 3 years after the natives chased Custer out on his ear and this is the guy of whom the eastern political writers would say, "Go on and fight a few battles and we will make you president and * * *"—but the natives did not quite agree with his desire.

It must have been an interesting place to come to back in 1879, but they came out here, as did a lot of other physicians who graduated from top medical schools of the day. Now, recently, we are finding an abject shortage of physicians, graduating from wherever, who are willing to go to the small rural communities or to the Indian reservations which are akin to the small rural communities. Why is that?

Mr. RAYMOND. The Indian budgetary process is such that a person who has specialized in a particular field can earn 10 or 20 times the amount of money in his specialty in an urban area than he can in the Indian Health Service. There are slots open and needed on the reservations; o.b.-gyn, for example, where they desperately need a person with that specialty and he cannot be hired.

These graduated medical doctors, fresh with their shiny new M.D. degrees and their residencies completed, have gone through those medical schools with the latest techniques, the latest methods of applying their knowledge and then they go to an antiquated reservation hospital where the supplies and the equipment are 50 years behind their times. My mother died in one of those hospitals. I know all about it.

I am not here to bring you a fancy book full of statistics. I do not need to prepare a speech, Senator Andrews. I have spent a lifetime preparing and I know these things and these other doctors, if I can call non-Indian doctors other doctors, are not going to come here to stay. They are few and far between. Although we have had a few great ones now and then. For the most part they come to serve their time, as it were, and then they scuttle back as fast as they can to the big

city where they can earn the big bucks and live the good life and according to their standards, the life on the reservation is not that.

Senator ANDREWS. But what you are saying, Art, without reservation is that the medical needs of the Indian people can best be served by training native Americans, training their own to go back and serve them because they prefer to stay on the reservation. They have a deep-seated commitment to the reservation, to their people, and to their area.

Mr. RAYMOND. That is right, sir.

Senator ANDREWS. They want to live there, and so they will get the training and will go back and serve their people well.

But to get back to the other question once again; in your knowledge of the Indian feeling, do you feel that it is easier for an Indian patient to consult and meet with and listen to an Indian doctor than a non-Indian doctor?

Mr. RAYMOND. Absolutely, sir.

Senator ANDREWS. So that we probably would see the patients on the reservation going in to see an Indian doctor before whatever they are bringing to him has progressed to the point where the treatment of it would be far more difficult and far more costly.

Mr. RAYMOND. Yes, sir.

May I give you one example outside of the medical field. I used to be a political reporter. I also used to cover court sessions. I do not know how many court sessions I have covered, but when one does, one soon learns the processes and the procedure.

I do not know how many times I sat there in a courtroom and saw American Indian defendants stand before the bench and have learned judges say to that American Indian defendant, "Look me in the eye. What's wrong with you? Can't you look me in the eye?" And you see, this is a part of our heritage and our background that when you do not look a person in the eye, you are paying all the respect to that person that you can muster from within yourself. So that defendant is doing everything he or she can to pay that kind of respect to the person of a judge. These learned judges do not know those things. They do not understand those things.

It is exactly the same way with America, with doctors. They do not know and they do not understand. They may understand how to do an appendectomy but medicine is more than doing an appendectomy. It is social and it is human and we cannot do it on a once a week basis. We need more doctors, not less. We need more facilities, not fewer. I do not know what else. If you have any other questions, sir—

Senator ANDREWS. You said it very well, Art, and we appreciate it. We appreciate it very much. Thank you for taking the time to come down.

We now have a panel of four: Jim Claymore, Elizabeth Demaray, Manny King, and Kerry Hartman, all active workers in INMED. Let me assure you that your separate statements will be included in total in the record so that we will have a complete record and if we could have you summarize them so that we could get some questions in the record we will make a more complete record that way in the time that we have available.

Jim, do you want to start out?

**STATEMENT OF JAMES CLAYMORE, CHAIRMAN, ADVISORY BOARD,
INMED PROGRAM, ACCOMPANIED BY ELIZABETH DEMARAY,
MANNY KING, AND KERRY HARTMAN, ALL OF THE INMED PRO-
GRAM**

Mr. CLAYMORE. Yes. My name is James Claymore. I am a Sioux from the Cheyenne River Reservation. Accompanying me is Elizabeth Demaray, Manny King, and Kerry Hartman. The three are working directly with the INMED program. They are the staff up here.

If I appear to be a bit nervous, I am; very much so. Nervousness due to the fact that the program itself is so significant for the people on the reservation that I hope that we will be, or I will be able to say a few words here that will certainly give testimony to the importance of it.

Now, I am chairman of the advisory board to the INMED program. We are 22 reservations, each one having a representation on the board. Each one of us is a direct link between the INMED program—

Senator ANDREWS. Twenty-two reservations, sir, from how many States?

Mr. CLAYMORE. Five States. Those States are Montana, Wyoming, Nebraska, South Dakota, and North Dakota.

Senator ANDREWS. What happened to Minnesota?

Mr. CLAYMORE. Minnesota looked over at us for advice, I guess, but not at this particular time.

But we certainly are a group of people who are dedicated to what we believe would be the best for our reservation and we are just getting in the doctors to come here to the University of North Dakota, helping Indian students to get their degree or get a start here and finish up in other universities. We are, as I said, a direct link to the reservation and everything that happens here. We hope that we bring the reservation perspective to the advisory committee.

We assist in, or listen to, the budget that would be presented, maybe adding a little bit to it or taking something away. We are working or helping with the eligibility of students coming in here. We add to the strength of the program both here at the university as well as on the reservation by bringing the feelings of people to the reservation, and from the reservation to the university. I think these feelings are very important.

Art Raymond did a terrific job in presenting what is needed on the reservation through his words and I cannot add any more to it other than we are very much in support.

We advise INMED in relation to what is happening and what we think is going to benefit the program itself. We help in counseling students back on the reservation or counseling the tribal council itself in reference to what is happening at the University of North Dakota in reference to the medical school. We assist or give our advice in picking the director for the INMED program itself and we are happy to say that we have not made a mistake in picking our coordinator.

We certainly do have a shortage of doctors on the reservation and it is through this program that we are beginning to introduce youngsters on the reservation to the possibility of becoming Indian doctors.

We have not had that role on our reservation before, but now we are moving in a direction where youngsters coming up from elementary grades on into high school and the rest are going to college seeing that we, we as Indian people, are also able to take some of the courses that are technical and then become doctors and come back to the reservation and administer.

We have had educators who have come back to the reservation so we are not short on our teachers. We have quite a few Indian teachers. A lot of them are not back on the reservation but going elsewhere.

We have not had the role of a doctor. We are getting to that point where we are having that role so our young people are going to be able to move on.

We are trying to do something here and are doing it. Our statistics prove that we are doing it and being successful.

Civilization came over just a little over 200 years ago and we were trying to catch up, or they told us we were supposed to be catching up to civilization. We have our own feelings about that and now for the past 10 years we are trying for the same thing in the medical profession and I believe we are doing it. I think we have cut a lot of lines and I think we are proving it to a lot of people as well as ourselves. I think we are the people that we have to prove ourselves to. We proved that we are capable of doing it.

We think the advisory board to the university itself is very important and it does bring to the university knowledge of what we have on the reservation and certainly the people in the INMED program itself have taken it and used it, and, as a result of it, we have had some top people going out. I certainly feel that any funding that comes in should not be cut.

We have summer programs that need to be adjusted at this time because of lack of money. But these youngsters coming in, are seeing what is happening. They are getting the university feeling, getting some terrific counselors, and terrific teachers here that certainly will move in a direction that will give us that.

Senator ANDREWS. How many students, Jim, enrolled in the INMED program receive Indian Health Service scholarships?

Mr. CLAYMORE. We have 53 people that are receiving Indian scholarships, or 52. Then we have 25 that are participating without the Indian scholarships.

Senator ANDREWS. What reasons have been given for the denial of these scholarships?

Mr. CLAYMORE. Well, at times the funding itself is very limited and it is natural that we are going to be trying to find the student that is most capable, most representative of our particular program.

Senator ANDREWS. Have you experienced any problems related to the continuity of funding from IHS for scholarships?

Mr. CLAYMORE. I think we should possibly point out that when we first started out we had somewhere in the neighborhood of \$1 million for the program and I believe we dropped down to about \$250,000 now and that is the difference. We need the additional money to do the work we can. Simply an additional \$1 million was used to get the program off the ground and it took a lot of money, and a lot of people

to get it going. Now we can thank the Lord that we can streamline, but we cannot streamline too much or we will not have a program.

Senator ANDREWS. Do payments to cover these tuition scholarships arrive prior to the due dates for the tuition?

Mr. CLAYMORE. I believe Manny King can answer that a little bit better than I.

Mr. KING. My name is Manny King.

I am a Northern Cheyenne from Montana and I have been working with the program for about 5 years and I work with grant awards. Students are issued those each year and it projects what they will get for the academic year. Students are billed out of the university business office here and in general it takes about 4 to 8 weeks, but normally the university likes that payment at least 2 to 3 weeks after school starts. We have made arrangements with the university to have those payments in up to 8 weeks after school starts.

Senator ANDREWS. You know the payments are coming then, so you assure them they are coming, even though they do sometimes arrive late.

Mr. KING. Yes. If they receive that notice of grant award it says on that notice of grant award that a student will receive such and such money for tuition and fee payment and we show them that and verify that the tuition fee costs will be paid.

Senator ANDREWS. This is not the only program that the Federal Government plays fast and loose with prompt payment. You know, if you do not pay your taxes on time you sure get a penalty slapped on you. But the Federal Government can slow its payment from 30 to 120 days and not even blink.

Do you have anything else to add?

Mr. KING. No, sir.

Senator ANDREWS. Elizabeth?

Ms. DEMARAY. It has taken a few years for that process to become workable. Before that, it had been months sometimes. It has taken at least 10 years to work out that process. We have been working with the institution and they have been very cooperative.

I have been working with INMED since 1973 as a counselor in the summer program and I direct the summer program right now. I would like to mention that my biggest concern is for the summer program and for the pool of applicants that we have been getting over the past 10 years. I believe Dr. Ray mentioned that we get about 40 students per year. That is an average. This year we have 50 students. Last year we had 60, and that is the junior high and senior high program.

Senator ANDREWS. Is this a different group each year?

Ms. DEMARAY. No, it is not. We try to keep in the students who prove that they have abilities and prove that they want to be in the program.

Senator ANDREWS. In other words, if you get a group of likely prospects one summer, then you invite the most promising of those back for the second summer.

Ms. DEMARAY. Yes. And, each year we receive something like 200 applications, so it is a very difficult process. We have four people who make the selections of the students so we try to choose the most promising applicants.

The selection process gets really, really difficult and we have many applicants each year. My major concern is what is going to happen to these students in a few years? I can see the scholarship program being cut and the BIA scholarships being cut. This is not good. What I am looking for is what is going to happen to our students, 50 or 60 of them from the past year, and since 1973.

Senator ANDREWS. But in your experience, the system works when you keep inviting back the most promising students.

Ms. DEMARAY. Yes, sir.

Senator ANDREWS. Do you encourage the others to use funds that may be available for them to perhaps take nurse's training? Do some of them end up doing that?

Ms. DEMARAY. We do some career counseling as part of the program, or we did—Manny and Kerry do career counseling with the students and inform them of all of the other alternatives. We have one special class during the summer institute program where we bring in a lot of other people who can demonstrate what they do in their field.

Senator ANDREWS. Kerry, would you like to add something to that?

Mr. HARTMAN. Yes. A slightly different note. My name is Kerry Hartman. I have been working with INMED for about 6 years. I would like to say a couple of general things.

I would like to thank you very much for the previous support that you have given Indian health in general and the INMED program in particular. I would like to thank all of our friends waiting in the back of the room here. There are many, many concerns in Indian health and INMED is the one we are bending your ear on right now, and I thank them for waiting on us.

I have just one thing on Public Law 94-437, the title I health manpower and section 103. There was an amendment over the last 2 years to add a 4-year undergraduate scholarship. I have right here the Federal Register from May 17, where I see finally, the Indian Health Service is trying to reimplement that 4-year scholarship.

We have been told that this year there is not going to be any 4-year scholarships offered and that distresses us immensely. It distresses the students who are applying even more.

The 2-year scholarship is good for a student who is ready to go into medical school in 2 years or who is ready to go into nursing school for 2 years, but the Bureau of Indian Affairs' statistics show that it takes them 5 years to go through school. It takes them about 5 years in INMED. I am proud to say, we do it in about 5 years.

At any rate the 4-year scholarship is extremely needed and I am optimistic to see these regulations and guidelines in the Federal Register. I just sincerely hope that the 4-year scholarship will once again be implemented.

Senator ANDREWS. What about the use of other regular funds; BIA funds for education? Now, maybe we are sitting back there in Washington blithely thinking that something is happening that is not happening. It is my understanding that any Indian student who is capable of being enrolled in a college would have his or her scholarship funded through the BIA.

Mr. HARTMAN. That is a nice dream. I have with us, and I think next you are going to hear from a bunch of our students. I have been

working with the students for about 6 years. We currently have, as Dr. Claymore mentioned, approximately 20 or 25 students participating in our program on what we call indirect funding. They are using the Pell grants, the BIA. It is not sufficient. It is not there in every case. It is definitely not sufficient.

In fact under our scholarship program, anybody with a family is eligible to receive supplemental funding. Our average student is older, is married, and has two children. They are eligible through the financial aid office to receive some of this other funding to supplement our scholarship because our scholarship is not sufficient. So, yes, that method is there, but it is not sufficient either way alone, with ours, or with just going through BIA funding.

I wish we had some BIA educational specialists here because they could tell you. They have hundreds of applications and they cannot serve all of the people that they have.

Senator ANDREWS. I was on the old Indian Affairs Committee in the House of Representatives when Jim Haley was the chairman and about 19 years ago Mr. Haley, who has since passed on, came out with me and we went through several of the reservations in North Dakota. At that point in time, we were told by the BIA that any student from a reservation who was accepted in a college would have their scholarship taken care of by the BIA and that there was no problem. I have been going along blithely thinking that that essentially was still the case. Certainly it would be the greatest investment that you could find, training for job opportunities.

When Congressman Haley and I were there on one of the reservations, we found the case of a young man who had been trained by a program, not at the college level, but as a welder. They found a job for him out in California. He went out to California. He was a welder working there. They had two children I think. He was called back a couple of years later because his mother died and he came back for the funeral. As is the tradition, they provided food and sustenance for the family's friends and all of that and at the end of the period of mourning he was ready to go back to his job but did not have the money to get back out there so he and his wife and his two children went in to the BIA and said, "Look. We cannot afford to get back to our job that is waiting out there." The BIA said, "Sorry. We trained you and we sent you out there 2 years ago and we are not going to send you out again." When we saw them it was 3 years later. They then had five children and they were living on welfare and the tribe had chosen the idiotic posturing of the BIA in some of these programs. We thought we had broken through that. I really thought we had made progress to the point where qualified Indian students did in fact have scholarships.

That is the reason we have these hearings. We learn, and when we finish these field hearings, let me assure you that we are going to take the insights you have given me and hold a hearing in Washington to bring all these pieces together and find out where things that we assumed were being done are slipping through the cracks.

Mr. HARTMAN. I agree with you there, Senator. One of the things the statistics prove is that Indian students are desiring more and more, from what we have found, to go to higher education. Our ap-

plication pool increases every year. This year for our summer institute we had approximately 300 applications for our 50 or 60 positions. For our scholarships we had, oh, 80 or 90 interested and approximately 40 that were completed. The scholarship office tells us we will be lucky to get five scholarships. The interest is out there. The BIA has the same problem. They are getting hundreds and hundreds of applications from students that want to go to college.

Senator ANDREWS. Let me ask one final question while I have the four of you here who are working with INMED. Could you give us a little insight into INMED's uniquely culturally oriented program?

Mr. KING. I would like to address that. Since I have been working there we have been able to implement a number of programs. They are not really programs. They are just facets of INMED.

One, we call the buddy system, where we have been encouraging our older students to work with the undergraduates. I think one of the things about INMED is that they have a learning resource center available where the students are divided in two groups. We have a number of students in the halls that meet with the medical students and the medical students more or less take them under their wings and try and give them a little better background on what they are going to encounter; some of the courses that they are going to take, study habits, test taking, et cetera. They try and encourage them as far as studying and course work.

We also have encouraged our students to go back to the reservations and work in clerkships and externships. The clerkships are the second year medical students. They go back for about 3 weeks and work on the reservation. We really encourage them to go back to the hospitals and clinics. We have a couple students go up to Belcourt. We have one go down to Sisseton. We have a couple go to Fort Yates. I think Lois [Dr. Steele] has been pushing our students to go into a setting where it is beneficial for them rather than go to an IHS facility where they really do not have the needed equipment, et cetera. There are a lot of trauma and emergencies that they are not going to see at a non-Indian setting so we also have undergraduates there and we encourage our students to do this as part of the scholarship.

With this, they work up to 120 days during the summer and they are placed in medical records, or as nurse's aides. Some of our students will assist the physicians.

We had one incident where one of our students unfortunately got into a situation where he had to work the lab by himself. There is such a need out there. For example, he was a medical technologist assistant out on Fort Berthold and the medical technologist had some kind of problems there and was transferred out, so consequently they did not have a medical technologist and the student had to assume that responsibility with only a very limited amount of training. I would say he was there maybe 3 weeks and he was the med tech for the Fort Berthold clinic and that was just two summers ago.

We have a lot of interest in the externship program. We just cannot get them out there.

The extern program is only geared for 104's. 104's mean professional students who are receiving a title I section 104 payback obligation in which the students receive scholarships for professional programs such

as medicine, nursing, medical technology, and physical therapy. They sign a contract that says the student has to pay back a minimum of 2 years and it is 1 for 1 after that and they sign it up to 4 years. Those are the students that are eligible for this program and they are the only ones that are being able to be funded this year. This year we submitted nine to the Indian Health Service and we were awarded only four.

We received a lot of interest in Rapid City, to send one of our students down there and work in the lab. They had called and requested a student a couple of summers. So that is one of the aspects.

We really try to encourage them to go the social steps. We have had dances and we have sponsored a couple of powwows in the last 2 or 3 years and a group called the Red River Singers and we have about seven or eight of our students involved in that. We also have sponsored workshops.

One of the things that we do have, as far as Indian people in general here at UND, is we have a lot of single parents, students who have a child or two. They are on their own through the situation of divorce, separation, et cetera, and there really is a need to try and feel the needs for comradery, just being able to identify with each other. Even within that group there are separate groups. Older students with children, single parents, younger single parents with children, spouses of medical students—all of them encountering a lot of stress and the hardships that accompany the process.

Senator ANDREWS. But you are there to help.

Mr. KING. We are there to help. Lois [Dr. Steele] is there. She is in her office. We have a staff that works late hours in the night. We try to keep services as much as we can.

Senator ANDREWS. Thank you very much. You have been most helpful.

Jim, one final question. What level of funding is required to support the INMED program and to assure the INMED program continues its success? Do you have a dollar figure?

Mr. CLAYMORE. I have been advised that somewhere around \$850,000 would probably—and more certainly would be—

Senator ANDREWS. Oh, yes, we know that.

Mr. CLAYMORE. I would like to make one correction here. I am not a doctor.

Senator ANDREWS. Oh, no. But you are being complimented by Kerry who addressed you as that. But let me compliment you all one other way, all four of you. Your prepared statements are excellent. It is material that will be invaluable to us and we appreciate your help and your appearance. Thank you very much.

Mr. CLAYMORE. Thank you very much.

[The prepared statements follow. Testimony resumes on p. 49.]

PREPARED STATEMENT OF JAMES CLAYMORE, CHAIRMAN, INMED'S, ADVISORY BOARD, EAGLE BUTTE, SD

I am here in behalf of INMED and its tribally appointed Advisory Board representing 100,000 Indians from the five states area of North Dakota, South Dakota, Wyoming, Nebraska, and Montana to request continuation of INMED and the Health Manpower Scholarship Program when Congress reauthorizes the Indian Health Care Improvement Act. INMED 's requesting to remain as a

viable means by which the special government-to-government relationship and trust responsibilities of the Federal Government to provide adequate health care to the Indian nations can be fulfilled.

Thank you for allowing us to appear before you. My name is James Claymore. I am the Chairman of the Indians Into Medicine Program Advisory Board. With me are the Program's Assistant Director Elizabeth Yellow Bird Demaray, College Coordinator Manny King and Assistant College Coordinator Kerry Hartman. We are here on behalf of the INMED Program at the University of North Dakota School of Medicine, and the tribal appointees from 22 reservations in five states who make up the INMED Advisory Board. We are here to request your continued support for the INMED Program, which is a line item in the Indian Health Care Improvement Act. During fiscal year 1982, INMED had 52 students receiving IHS scholarships and 25 additional students participating in the Program but not receiving IHS scholarships.

The administration's proposed budget for fiscal year 1984 would terminate the INMED program and hamstring the scholarship program by funding only 70 nursing students as new starts no new starts for medicine, dentists, occupational therapy, etc. It appears to us that IHS is trying to change its responsibilities, as outlined in the Indian Health Care Improvement Act, by the budget process, without any thought as to the real need for the INMED program and the scholarships.

INMED is cost-effective. Our students have a low drop-out rate in some of the most difficult curriculums in the University. The Program's drop-out/dismissal rate is annually between 10 and 20 percent. For Indian students nationally, surveys yield drop-out rates that are drastically higher. Chavers (1979) estimated the rate to be 85 percent, while McDonald (1978) found the dropout rate for Indian students to be between 79 and 83 percent.

Why is the drop-out rate for Indian students so high? McDonald in 1978 cited the major reasons as: (1) The nature and equality of (students) previous education, (2) Personal finances, (3) Institutional and personal discrimination, (4) The lack of persuasive role models available to students, and (5) Cultural differences between the student and the institution. A 1977 United States General Accounting Office report on the Bureau of Indian Affairs grant program denoted similar reasons for Indian students dropping out of college, including (1) weak academic backgrounds, (2) lack of study skills, (3) negative self-images, (4) lack of basic skills in English, mathematics and sciences, (5) lack of adequate career guidance, (6) culture shock, and (7) inadequate counseling, remedial and tutoring services.

INMED is a total-support program, which has proven itself successful by helping Indian students through these and other barriers to success. The Summer Institute more adequately prepares students for college—academically and personally. College and professional students are provided cultural and financial support, role models, tutoring, study skills training and career and personal counseling. The Program's students are provided with a climate geared toward success.

Funding Indian health manpower is not a give away, it is an investment in education and also in health. INMED's graduates will pay back in taxes the money that has been spent on them, while also providing Indian people with vitally needed health care.

Thirty-two physicians have graduated through the sponsorship of INMED, and fifteen of them have finished residencies. All but four of these graduates are working or have worked with Indian people. Two more residents completing their training this summer have signed up with Indian Health Service for placement this fall.

In addition to these physicians, two nurses, one dentist, one Master of Public Health and one physical therapist have completed their degrees through INMED. All five of these graduates are working or have worked with Indian health programs. A total of thirty-eight health professions have graduated through this Program. According to the IHS scholarship office, one-third of all IHS scholarship recipients who graduated in 1982 were INMED students.

Congress stated in 1980 that the section 103 scholarships should be awarded for up to a four-year period. Attached material notes that IHS complied with this guideline last year. This year IHS officials state that there are no regulations to allow awarding section 103 scholarships for four years, even though Congress approved the four-year cycle in May, 1980 with the reauthorization of PL 94-437. We note that IHS may finally carry out Congressional directives and write these regulations.

The uncertainty of future funding has probably had an adverse effect on students' attitudes and achievement. INMED dismissed seven students this spring for unsatisfactory grades. The Program has tightened academic standards to insure that only those students with definite career goals and the academic ability to succeed are funded. Two INMED students with the potential to become fine doctors were granted leaves of absence this spring for personal reasons.

INMED's results have been unparalleled thus far. While achieving these accomplishments, INMED has remained cost-effective. The Program's administration costs have been kept below 30 percent of the total program budget. The remaining 70 percent has been programmed for functions oriented toward direct services for the INMED students. INMED's cost for educating one physician is far below the national average cost of \$100,000 as estimated by various medical schools and organizations.

The INMED director has also been invited by the UND School of Medicine to help plan and implement reservation-based residency programs. INMED endeavors to train physicians who will settle permanently on reservations; physicians who have received training geared toward isolated rural practice, and people who feel comfortable with and enjoy the rural lifestyle.

Other INMED sponsored activities, including a health fair at last fall's National Congress of American Indians convention and assistance with tribal health programs, have resulted in INMED serving as an important health resource for the Indian community.

There has been discussion of parity of the numbers of health personnel to meet Indian health care needs. The statement has been made that IHS is within 50 percent of parity with the number of health care professionals serving the general population. Conversely, a 50 percent shortage of staff is expected in the IHS Aberdeen Area, by July 1, 1983, and a 30 percent shortage in the Billings Area.

According to the Association of American Medical Colleges, the number of Indians entering medical schools is decreasing. The AAMC has also stated that the over abundance of physicians predicted by the GEMNAC report does not include physicians practicing among minority and rural populations, the populations INMED endeavors to serve.

Human Resources Services Administration has instituted a private practice option for recipients of the scholarships that defers the service payback to Indian people which is vital to Indian health care. Under the private practice plan, medical graduates can receive a low interest loan of \$10,000 and permission to set up private practice in a shortage area. An option that looks far more attractive than serving at a lower salary at variable working conditions with IHS.

Is this cost effective? There are no permanent physicians in some IHS hospitals and clinics at the present time and turn over of personnel is high. The private practice option will only make staffing Indian health facilities more difficult.

Your attention to the serious problems in Indian health care, and the important contribution health manpower development can make, will be greatly appreciated.

INMED FACT SHEET

INMED has assisted a total of 40 Indian health professionals educationally, including 32 physicians, one dentist, one M.P.H., and two Bachelor¹ degree registered nurses, one physical therapist, one medical technician, and a health educator.

INMED is currently offering complete financial, academic, and personal support services to 32 pre-professional and 22 professional students.

INMED has enrolled 169 in pre-professional academic curricula since 1973.

INMED has organized and implemented a Summer Institute for high school and college students each year since 1973. Over 200 complete applications have been received annually for the 20 to 50 available positions. To date the total enrollment in Summer Institute is 443.

INMED is governed by an all Indian Advisory Board which is comprised of an appointment tribal official from each of the 22 tribes in INMED's service area (North Dakota, South Dakota, Montana, Wyoming, and Nebraska), plus

¹ Currently enrolled in medical school.

several charter members. This Board has provided direction, policies, and priorities to the INMED Program continuously since 1974. This Advisory Board is INMED's linkage to the desires, needs, and resources of the 100,000 Indian people in the INMED service area.

INMED has an overall retention rate of 80 percent for pre-professional students and 95 percent for professional students. The national drop-out rate for Indian medical students is estimated to be 12 or 88 percent retention rate while the Indian college student retention rate is about 50 percent. INMED staff has provided over 900 hours of tutoring and 3,500 hours of academic, financial, and personal counseling yearly as part of INMED's extensive support services system.

INMED staff uses telephone, written communication, and personal visits to make over 13,000 contacts annually to Indian students, parents, tribal officials, counselors, and others. These contacts, within and without the 22 reservations service area are aimed at increasing the interest, awareness and motivation of Indians toward the health professions as well as retention of selected students.

Since 1973, INMED has produced numerous publications, including a color-book, paper doll book, 2 volumes of physician biographies, health career game, and a multi-colored comic book. The Program has also produced audio-visual materials, including Program presentations, teaching video tapes on genetic counseling and photo dermatitis a puppet "health career" education show, and a video tape entitled the "Red Medicine Road", that combines some Indian medical philosophy with motivational techniques.

INMED has produced twelve workshops with an emphasis on health issues i.e., alcoholism, tuberculosis, traditional medicine, health career education, diabetes, health manpower training, etc., of the Indian people.

INMED's formal linkages at UND have expanded to include working with the Medical Technology Dept., College Nursing, and the Physical Therapy Dept. INMED is also involved in developing programs to sensitize the nursing staff and students to the culture and needs unique to the Indian people.

INMED staff and students have participated in the planning and implementation of all Indian social and cultural activities on the UND campus annually.

The University of Manitoba, Winnipeg School of Medicine and the Coordinator of Native Health Care Development for Health and Welfare, Canada, have visited the Program and used INMED as a prototype for projects they are developing.

In 1981, INMED assisted the UND School of Medicine and Indian Health Service in presenting educational and clinical programs on INMED service area reservations.

INMED has aided reservations in the research on health issue on the local as well as national levels.

Six issues per year of the INMED newsletter, *Serpent, Staff, and Drum* are distributed to approximately 500 individuals and organizations interested in Indian health care and education.

In 1983 one graduating INMED physician scored in the 95 percent on National Medical Boards II. Combined with his 99 percent on Boards I this student was in the 97 percent nationally for graduating physicians. This same student also received in 1983, the H.J. Kaiser Award for outstanding academic achievement nationally by a minority medical student.

INMED placed three special undergraduates with National Institute of Health Summer employment program for summer 1983, one special undergraduate in the National Institute of Health Carcinogenic Research Laboratory for one year appointment.

PREPARED STATEMENT OF ELIZABETH YELLOW BIRD DEMARAY, ASSISTANT DIRECTOR, MANNY KING, AND KERRY HARTMAN, COLLEGE COORDINATORS, AMERICAN INDIANS INTO MEDICINE PROGRAM

We are here in behalf of INMED and its tribally appointed Advisory Board representing 100,000 Indians from the 5-state area of North Dakota, South Dakota, Wyoming, Nebraska, and Montana to request continuation of INMED and the Health Manpower Scholarship Program when Congress reauthorizes the Indian Health Care Improvement Act. INMED is requesting to remain as a viable means by which the special government-to-government relationship and the trust

responsibilities of the Federal Government to provide adequate health care to the Indian nations can be fulfilled.

Thank you for this opportunity to appear before you. My name is Elizabeth Yellow Bird Demaray, the Assistant Director of the Indians Into Medicine Program (INMED), at the University of North Dakota. I am accompanied by Manny King and Kerry Hartman, College Coordinators for INMED. We are here in behalf of INMED and its tribally appointed Advisory Board (representing 100,000 Indians from the five states of North Dakota, South Dakota, Nebraska, Montana, and Wyoming) to request continuation of INMED and the health manpower scholarship program as a line item within the Indian Health Care Improvement Act. During F.Y. 82 INMED had 52 students on I.H.S. scholarships; and 25 students receiving alternative sources of funding. These numbers do not reflect Summer Institute students.

We have maintained the INMED administration and summer program budget at a reduced level of \$200,000 for the past three fiscal years. During this time the student numbers have increased by one-third and demands for student support services have increased accordingly. Fringe benefits, salary increases, maintenance agreements and other such costs outside the control of the Program have also increased. The items we could control such as travel, consultants, and number of personnel, have been adjusted to allow us to remain within the \$200,000 limit. Reductions will further curtail needed student services. Additionally, services to tribes would continue to be decreased. Students have also started to incur debts at higher levels as the Program is unable to help them with interview travel and some fees that used to be allowable expenses through the INMED budget.

We again request to remain as a separate line item for all sections of Title I so that INMED's "total program" concept and a more efficient cost accounting process be maintained. We are also attempting to secure print-outs from IHS on all INMED scholarship recipients for additional follow-up and cost control.

INMED has proven that it can produce fully qualified medical school candidates. Thirty-four physicians have graduated through the sponsorship of INMED; fifteen have finished residencies and are practicing medicine. All but four of these graduates have worked or are working with Indian people.¹

The faith and help from Congress each year has enabled the University and twenty-two reservations represented by INMED to work at solving the continued shortage of Indian Health Manpower. The continued commitment by the UND Medical School to offer five positions annually to entering freshmen students has been instrumental in INMED's success. This shortage will become more acute with the lack of alternate sources of financial aid for all medical students, especially Indian students coming from low income families. Title IV of the Indian Education Act has been helpful to students, particularly those with a larger number of dependents. There is no dependency allowance on the Indian Health Care Improvement Act scholarship. However, this funding source may not be available in the future. The Health Careers Opportunity Programs (HCOP) helped finance the recruitment activities of INMED, currently in its second year of a three-year cycle of program funding.

There has been discussion of "parity" of numbers of health personnel to meet Indian health care needs, and statements that IHS is within 5 percent of achieving parity with other health care providers available for service to the general populations. This is hard to understand at Standing Rock Reservation where over 200 physicians came in and out during the past two years. There are no permanent physicians at Cheyenne River in a four doctor station, and only one at Standing Rock in a five doctor station. Fort Berthold has only one physician who is leaving soon with no replacements in sight in this two physical station. A 50 percent shortage of positions in the Aberdeen area, and a 30 percent shortage in the Billings area by July 1, 1983, is anticipated. These positions do not reflect the numbers need to receive optimum care, only the numbers allocated per service area.

INMED's current graduates are signing up for IHS, but many are going to Oklahoma and Alaska. We are just starting to produce for Aberdeen and Billings. This is partly due to the necessity to break barriers in IHS to allow physicians to return to their own areas and partly due to the need for a "critical mass" of physicians in a place before it becomes easier to recruit to fill vacancies. The

¹ Summary sheets of current numbers of graduates are attached.

problem of training students from this area has been met only with the summer programs that start these students in junior high and high school. We have two third-year medical students in this category who will return to the Aberdeen area eventually to practice because that is where their home is. This Spring we will graduate the first Indian Physical Therapist from UND who wishes to remain in South Dakota.

The need for nurses is as acute. The lack of Commission Corps nurses will cause a serious shortage at the higher levels of training. At the present time an acute health manpower shortage problem still exists in the Aberdeen Indian Health Service area, which is part of the INMED Program service area. Eighteen physicians and 27 nursing vacancies were being reported at this time by the Area director.² The constant physician turnover has placed increased responsibility on the nurses to provide continuity of care.

With cutbacks in contract care monies, the IHS Service Units have had to meet an increased demand for services with less personnel and back-up. Poverty levels in the reservations in our area are the highest in the nation. Poverty breeds more sickness and need for health services, yet most help is being reduced, not increased. When we attempt long range goals to provide Indian Health manpower, via INMED and the scholarships, short sightedness abounds in the higher levels of the bureaucracy as well as retaliation for a job well done. Parity of Indians serving Indians in health takes time. We are slowly improving the numbers, but it takes ten to twelve years to get a person ready to practice medicine.

² Numbers reflect projections at IHS spring recruitment meeting.

INMED PROGRAM

PROFESSIONAL GRADUATES BY YEARS AND DEGREES

1976	MD - 1
1977	MD - 4 BSN - 1
1978	MD - 6
1979	MD - 5
1980	MD - 6 DDS - 1 MPH - 1
1981	MD - 3
1982	MD - 4 BSN - 1 B.S. - 1 (Med-Tech)
1983*	MD - 6 PT - 1
1984*	MD - 7 MPH - 1
1985*	MD - 7 BSN - 3 PHD - 1

*Projected from current professional school enrollment and student's choice of decelerated programs.

Prepared June 1, 1983
Kerry Hartman
Counselor/Research Analyst

KH/ab

INMED HEALTH PROFESSIONAL GRADUATES
1973 - 1983

Since the INMED Program became operational in 1973, thirty-eight professionals have been graduated through the auspices of the Program. Following is a listing of graduates, annually; the health profession in which they attained their degree; and where they are presently located, either in their residency programs or clinical practices.

<u>NAME*</u>	<u>YEAR OF GRADUATION</u>	<u>HEALTH PROFESSION</u>	<u>TRIBE</u>	<u>RESIDENCY PROGRAM OR LOCATION OF PRACTICE</u>
1	1976	MD	Yankton-Sioux	OB/GYN Practice at Minot, ND; previously at IHS hospitals in Ada, OK and Tuba City, AZ
2	1977	MD	Seneca	Internal Medicine Practice - Bastrop, LA (private practice)
3	1977	MD	Southern Cheyenne	OB/GYN - Pittsburg, PA (private practice)
4	1977	MD	Delaware/Powhatan	1st year residency in psychiatry at University of Oklahoma, OK; previously in Preventive Medicine Practice with IHS at OK State Dept. of Health's Alcoholism Program; GMO at IHS hospitals in Lane Deer, MT; and intern in Albuquerque, NM, Indian Alcoholism Program
5	1977	MD	Cheyenne River Sioux	Internal Medicine practice at Dillon, MT (private practice); previously served on Oklahoma City Indian Health Board
6	1977	BS, Nursing	Cherokee	Working in Medical Surgery at Dickinson, ND (privately operated hospital); previously with IHS at Cheyenne River, SD
7	1978	MD	Cherokee	Family practice with Native Alaskan services on Pribilof Islands, AK
8	1978	MD	Cherokee	Residency in Family Practice Center at Kansas City, KS
9	1978	MD	Choctaw	GMO at Creek Nation Community Hospital, Okemah, OK; previously with IHS at Philadelphia, MS; Broken Bow, OK and Macy, NE
10	1978	MD	Crow	Internal Medicine Practice - HMO Group Minneapolis, MN (private practice) Discussing placement with IHS Moses Lake, WA.

Updated: June 1, 1983
Kerry Hartman
Counselor/Research Analyst

<u>NAME*</u>	<u>YEAR OF GRADUATION</u>	<u>HEALTH PROFESSION</u>	<u>TRIBE</u>	<u>RESIDENCY PROGRAM OR LOCATION OF PRACTICE</u>
11	1978	MD	Munsee/ Stockbridge	ENT practice in Cherokee, NC and contract care with IHS
12	1978	MD	Chickasaw	General practice Internal Medicine (location unknown)
13	1979	MD	Tsimsiam-Tlingit	Internal Medicine residency (transferred from Portland, OR) at Greenville, NC; previously in General practice doing Loco Tenums with IHS and House Calls Inco.; Discussing permanent placement for her and her husband with IHS
14	1979	MD	Mohawk/ Oneida	OB/GYN practice at Saginaw, MI (private practice)
15	1979	MD	Choctaw/ Cherokee	Internal Medicine Practice in Denver, CO (private practice)
16	1979	MD	Mohawk	Family Practice at Star Lake, NY
17	1979	MD	Comanche	Residency in Family Practice at Albuquerque NM; contract with IHS at Lawton, OK beginning July, 1983
18	1980	MD	Seminole/ Cherokee	General Practice (completed 1 year of pathology residency) at Philadelphia, MS IHS/Tribal Hospital
19	1980	MD	Navajo	Family Practice at Farmington, NM
20	1980	MD	Comanche	Second year residency in Anesthesiology at Temple, TX (completed 1 year of flexible internship)
21	1980	DDS	Cheyenne River Sioux	Kellogg, IL (private practice); previously one year of practice at Cheyenne Eagle Butte Reservation, SD
22	1980	MD	Chippewa	Third year residency in OB/GYN in Grand Rapids, MI
23	1980	MD	Oglala Sioux	Third year residency in Family Practice at Saginaw, MI
24	1980	MPH	Chippewa	Assistant Director of Oakland, CA, Urban Indian Health Clinic 1 year left for health reasons
25	1980	MD	Chickasaw	Second year residency in Ophthalmology at Houston, TX (completed 1 year of flexible internship)

Updated: June 1, 1983
Kerry Hartman
Counselor/Research Analyst

<u>Name*</u>	<u>Year of Graduation</u>	<u>Health Profession</u>	<u>Tribe</u>	<u>Residency program of Location of practice</u>
26	1981	MD	San Felipe Pueblo	Second year residency in family practice at Omaha, NE
27	1981	MD	Cherokee	Second year residency in family practice at Wichita, KS.
28	1981	MD	Sisseton/Wahpeton	Second year residency OB/GYN at Milwaukee, WI
29	1982	MD	Cherokee	First year residency in Internal Medicine at Baltimore, MD
30	1982	MD	Creek	First year residency in Peds at New York
31	1982	MD	Choctaw	First year residency in family practice in Amarillo, TX
32	1982	MD	Eskimo	First year residency in family practice, Youngstown, OH
33	1982	B.S. Nursing	Three Affiliated tribes	Pt. Yates INS hospital
34	1983	MD	Gros Ventre	First year residency in family practice Sioux Falls, SD
35	1983	MD	Cherokee	First year residency in psychiatry in El Paso, TX
36	1983	MD	Chickasaw	First year residency in Anesthesiology, U.C.L.A.
37	1983	PT	Sioux	Clerkship at Gallup Indian Hospital
38	1983	MT	Chippewa	First year medical student at U.W.D.
**39	1983	MD	Three Affiliated tribes	Not known as of date
**40	Did not Graduate	BS	Navaho	Health educator, Four Corners area.

*Legally we cannot supply the names without their expressed permission.

** #39 Received direct support during undergraduate years, but did graduate under the auspices of INMED.

** #40 Received training but did not graduate.

Up-dated: June 1, 1983
Kerry Hartman
Counselor/Research Analyst

KH/ab

INMED HEALTH PROFESSIONAL GRADUATES

1973 - 1983

These numbers reflect further explanation of INMED graduates service to Indian people. The numbers listed are from the attached list of INMED graduates.

- | | |
|---|---|
| 1) Numbers 1,4,5,6,9,13,18,21,24 | Have prior to 5/1/83 worked for IHS or an Indian organization. |
| 2) Numbers 4,6,7,17,23,33,37,38, 40 | Are currently working for I.H.S. or will be placed by 8/1/83. |
| 3) Numbers 22,26, 27, 28, 29, 31, 32, 34,35, and 36 | Are still in residency, but have done clerkship or rotation with IHS and intend to practice with IHS upon completion of training before 1985. |

Updated: June 1, 1983
 Kerry Hartman
 Counselor/Research Analyst

KH/ab

INDIAN HEALTH CARE AMENDMENTS OF 1959

DECEMBER 1, 1959.—Ordered to be printed

Mr. UDALL, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany S. 2729]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the House to the bill (S. 2729) to amend the Indian Health Care Improvement Act and the Public Health Service Act with respect to Indian health care, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House to the text of the bill and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

That (a) this Act may be cited as the "Indian Health Care Amendments of 1959"

(b) Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be construed to be made to a section or other provision of the Indian Health Care Improvement Act (50 Stat. 1495).

DEFINITIONS

Sec. 2. (a) Section 461 is amended by striking out "Secretary of Health, Education, and Welfare" and inserting in lieu thereof "Secretary of Health and Human Services".

(b) Section 4(h) is amended by striking out "composed of urban Indians" and inserting in lieu thereof "governed by an Indian controlled board of directors".

(c) Section 4 is amended by adding the following new subsections at the end thereof:

"(i) Rural Indian means any individual who resides in a rural community as defined in subsection (j), who is an Indian within the meaning of subsection (c), and who is not otherwise eligible to receive health services from the service.

"(j) Rural community means any community that—

"(1) is not located on a Federal Indian reservation or trust

area;

"(2) is not an Alaskan Native village;

"(3) is not an urban center; and

"(4) has a sufficient rural Indian population with unmet health needs, as determined by the Secretary, to warrant assistance under title V of this Act.

"(k) Rural Indian organization means a nonprofit corporate body governed by a board of directors controlled by rural Indians and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of locally cooperating with other public and private entities for the purpose of performing the activities described in section 303(a).

INDIAN HEALTH MANPOWER

Sec. 3. (a) Section 103(c) is amended by striking out the last sentence and inserting in lieu thereof the following: "There are authorized to be appropriated to carry out this section \$3,000,000 for the fiscal year ending September 30, 1981, \$3,600,000 for the fiscal year ending September 30, 1982, \$4,000,000 for the fiscal year ending September 30, 1983, and \$4,500,000 for the fiscal year ending September 30, 1984."

(b) Section 103(b) is amended to read as follows:

"(b) Scholarship grants made pursuant to this section shall be for the following purposes:

"(1) Compensatory preprofessional education of any grantee, such scholarship not to exceed ten years.

"(2) Postgraduate education of any grantee leading to a doctorate degree in an approved premedicine, podiatry, preventive medicine, geriatrics, pediatrics, or podiatry curriculum, such scholarship not to exceed four years."

(c) Section 103(d) is amended by striking out the last sentence and inserting in lieu thereof the following: "There are authorized to be appropriated to carry out this section \$1,300,000 for the fiscal year ending September 30, 1981, \$1,600,000 for the fiscal year ending September 30, 1982, \$1,600,000 for the fiscal year ending September 30, 1983, and \$2,000,000 for the fiscal year ending September 30, 1984."

(d) Section 103(e) is amended by striking out the last sentence thereof and inserting in lieu thereof the following: "There are authorized to be appropriated to carry out this section \$900,000 for the fiscal year ending September 30, 1981, \$1,200,000 for the fiscal year ending September 30, 1982, \$1,400,000 for the fiscal year ending September 30, 1983, and \$1,600,000 for the fiscal year ending September 30, 1984."

(f)(1) The first sentence of section 252(a) of the Public Health Service Act is amended by striking out "and for each of the succeeding four fiscal years such sum as may be specifically authorized by an Act enacted after the date of enactment of this section" and inserting in lieu thereof "38,000,000 for the fiscal year ending September 30, 1981, \$10,000,000 for the fiscal year ending September 30, 1982, \$11,000,000 for the fiscal year ending September 30, 1983, and \$12,000,000 for the fiscal year ending September 30, 1984."

(2) Section 252(b)(2) is amended—

(A) by striking out "his" and inserting in lieu thereof "the applicable"; and

(B) by striking out "him" and inserting in lieu thereof "the Secretary".

Recommend changes to increase the effectiveness of Title I, making the effectiveness of Title I, making it a comprehensive Health Manpower Development mechanism:

Section under scrutiny: (Section numbers discussed here refer to those in "The Indian Health Care Amendments of 1980"

Section 103b (2)

(2) Pregraduate education of any grantee leading to an approved pre-medicine, pre-dentistry, pre osteopathy, pre veterinary medicine, pre optometry, or pre podiatry curriculum, such scholarship not to exceed 4 years.

Proposed changes:

Add pre-nursing, and pre-physical therapy.

Rationale:

1. Nurses and Physical Therapists are intricate parts of comprehensive health care delivery systems, both are in demand in Indian Health Service.

Justification:

1) Health care systems serving Indian people on/near reservations are currently severely understaffed in the Nursing and Physical Therapy Departments. Nurses and Physical Therapists will continue to be desperately needed in the foreseeable future.

Additional Comments:

This entire segment (2) of Section 103, and the 4 year portion of the IHS scholarship that is authorized by it was utilized in FY '82 and '83 as mandated by Congress but is not being implemented during the 1983/84 school year due to lack of regulating policies being drafted. (See attached copy of initial draft of regulations for Sec. 103 (b) The loss of the "Pregraduate" portion of the scholarship is extremely detrimental to the overall scholarship program. Title I was initially designed and later implemented to offer students a complete long-term dependable source of financial and academic support. Removal of this portion leaves a significant gap in the IHS financial aid scholarships.

Section under scrutiny

Sec. 105 (2) Any individual . . . period of the year"

Proposed changes

"Amend before "Section 104""

Add "Section 103 and Section 104"

Rational:

Students in Sec. 103 also deserve access to this work experience program. Such experience is necessary for admittance to some medical schools and so is cost effective.

Justification:

Pre-professional students can better prepare for eventual careers when academic coursework can be coupled with clinical experiences. This enables the pre-professional to make better, more informed choices of personal strengths regarding career selection and preferences.

SPECIFICATION FOR REGULATIONS FOR
INDIAN HEALTH CARE AMENDMENTS OF 1980

(AMENDMENT--Pregraduate education of any grantee leading to a baccalaureate degree in an approved premedicine, predentistry, preosteopathy, preosteopathy, preveterinary medicine, preoptometry, or prepodiatry curriculum, such scholarship not to exceed four years)

Pregraduate Education Scholarship Program

Scholarships may be awarded for the period (not to exceed four academic years) necessary to complete a recipient's pregraduate education to enable the recipient to qualify for enrollment in a graduate education program in medicine, dentistry, osteopathy, veterinary medicine, optometry and podiatry. Examples of individuals eligible for such grants are the individuals who: (a) Has completed high school and needs pregraduate education to enroll in a school of medicine, dentistry, osteopathy, veterinary medicine, optometry and podiatry; (b) Has a baccalaureate degree and needs additional pregraduate education to qualify for enrollment in the graduate schools listed above.

Eligibility

To be eligible for a pregraduate education grant an applicant must:

- (a) Be an Indian;
- (b) Have successfully completed high school education or high school equivalency;
- (c) Have demonstrated to the satisfaction of the Director, Indian Health Service the desire and capability to successfully complete courses of study in a pregraduate education program;
- (d) Be accepted for enrollment in or be enrolled in any accredited pregraduate education course or curriculum; and
- (e) Be a citizen of the United States.

Application and Selection

An application for a pregraduate scholarship grant shall be submitted in such form and at such time as the Director, Indian Health Service shall determine. An applicant must indicate:

- (1) The pregraduate education program the applicant wishes to enter, (2) the graduate education program the applicant wishes to enter upon completion of the pregraduate education program, and (3) whether the applicant intends to provide health services to Indians upon completion of pregraduate education of training by serving as described in section 36.333 of Federal Register Vol. 42, No. 223, Friday, November 18, 1977.

Retyped from original draft received from IHS by Lois Steele, M.D./Director/INMED Program, and Jean Brandt in early November, 1981. Final regulations never received as of February 1983.

Within the limits of funds available for the purpose, the Director, Indian Health Service, shall make pregraduate scholarship grant awards for a period not to exceed four academic years of an individual's pregraduate education to eligible applicants taking into consideration:

- (1) Academic performance;
- (2) Faculty or employer recommendations;
- (3) Stated reasons for asking for the scholarship; and
- (4) the relative needs of the Service and Indian health organizations for persons in specific health professions.

Scholarship and Tuition

- (a) Scholarship grant awards under this subdivision shall consist of:
 - (1) A stipend of \$400 per month adjusted in accordance with paragraph (c) of this section;
 - (2) An amount determined by the Secretary for transportation, tuition, fees, books, laboratory expenses and other necessary educational expenses.
- (b) The portion of the scholarship for the costs of tuition and fees as indicated in the grant award will be paid directly to the school upon receipt of an invoice from the school. The stipend and remainder of the scholarship grant award will be paid monthly to the grantee under the conditions specified in the grant award.
- (c) The amount of the monthly stipend specified in paragraph (a) (1) of this section shall be increased by the Secretary for each academic year ending in a fiscal year beginning after September 30, 1978, by an amount (rounded to the next highest multiple of \$1) equal to the amount of such stipend multiplied by the overall percentage (as set forth in the report transmitted to the Congress under section 5303 of Title 5, United States Code) of the adjustment (if such adjustment is an increase) in the rates of pay under the General Schedule made effective in the fiscal year in which such academic year ends.

Publication of a list of recipients

The Secretary, acting through the service, will publish annually in the Federal Register a list of recipients of scholarship grants under this subdivision, including the name of each recipient, tribal affiliation and school.

Eligibility Eroded, Funds Being Cut Health Care for Native Americans Stripped

By Nicholas D. Kristof
Special Contributor

The Indian Health Service, a branch of the Health and Human Services Department that cares for native Americans, is facing a crisis—in funding, staff and morale—that many doctors say already is having an impact on the 200,000 Indians and Indians who are eligible for its free health care.

"We can't buy the money to take care of everyone who needs it," a South Dakota doctor said. "Patients have to come in almost as emergency cases to be treated. Luckily we're not following the orders from higher up. They just want us to treat people who are dying on the doorstep."

A common complaint is that because there are no adequate standards as to how much Indian blood a person needs to qualify, many people are getting a free ride on the financially strapped program because of some distant Indian ancestor.

The tribes detesting their qualifications for membership, and critics say some tribes want as many members as possible to boost their political power and get more federal dollars.

Since the early 1960s, when Army doctors tried to curb smallpox outbreaks in some tribes, the United States has provided some medical services to Indians. The IHS evolved from treaties in which the federal government promised to provide medical care.

The IHS now provides free treatment to Indians in federally recognized tribes who are not covered by other health insurance programs, including Medicare and Medicaid. It runs 52 hospitals and many more clinics around the country, ranging from 100 facilities in Northern

Alaska to large buildings with 200 beds in cities like Phoenix.

What they have in common is a clientele who are frequently poor and relatively uneducated. Indians, who often live in isolated reservations on infertile land, are more likely than the general population to suffer from pneumonia, strep throat, hepatitis, alcoholism and otitis media, as major ear inflammation.

While Indian health facilities look much better than they did when the IHS was formed in 1955, they remain below the average in America. In 1970, the last year for which the IHS has data, the life expectancy of Indians was 65.1 years, compared to 70.2 years for the overall U.S. population. In the late 1970s, infant mortality for Indians was 16.4 per thousand live births, compared to 14.1 for all Americans.

But at a time when health care costs are rising dramatically—15.1 percent in 1981 alone—the IHS budget has been trimmed from \$253 million in fiscal 1981 to \$240 million this year. The Reagan administration has requested \$613.3 million for fiscal 1983, which begins Oct. 1.

Joseph N. Executive, deputy director of the IHS, said the agency has scrimped on travel and administrative allowances but has not had to cut back on services.

But doctors in the field who were interviewed disagreed, noting that they have been ordered not to contract for outside medical services except in emergencies. In many small hospitals, which lack surgical facilities and thus have to contract for almost all major services, the budget simply won't cover what must be done, doctors said.

For example, in the Cherokee area of Pheasant, 70 miles southeast of Tulsa, Oklahoma, is available each month for contracted services for a hospital serving 4,000 people. That area quickly—a coronary artery bypass operation may cost \$25,000 or more—so chronic problems often are not treated. Catastrophes may not be repaired and extensive surgery to replace joints is not performed.

"Nobody's going to the IHS just going to wait all the time," one doctor said. "It's quality of life."

The problem could get worse because of an impending shortage of doctors. The service for up to half the IHS physicians and dentists has been a rebalancing program for medical students who agree to serve in the IHS for several years. The Reagan administration plans to phase out that scholarship over the next three years.

Many doctors resent having to treat people with only a tiny amount of Indian blood. Congress has provided the sensitive issue of defining who is an Indian, so anyone registered by a tribe, and his or her spouse and children, can qualify for the free medical and dental care.

In some states, where Indians are isolated on reservations, and there has been little intermarriage, that is not an issue. But in others, such as Oklahoma, intermarriage was widespread, and a large portion of the population has at least a little Indian blood. In seeking for political power and federal assistance, tribes often have sided up anyone with any amount of Indian blood.

"Every body and his brother in part Indian around here, and if the

government is going to give free medical care, why not take it," one Oklahoma physician said.

That doctor, who works at a hospital in Pheasant, said 40 percent of his patients have less than one-quarter Indian blood, adding that patients with just 1/256th or 1/2048th Indian blood are not uncommon.

Dr. Charles B. Allen, clinical director of a hospital in Claremore, Okla., told of a patient who was less than one-eighth Indian, and two other IHS doctors, who added not to be libelous said they also knew of similar patients getting free health care.

Some IHS doctors object to having to treat those "blood, blue-eyed patients," and blame Congress for not restricting treatment. Others disagree. One Oklahoma doctor said it would be "pure unadulterated racism" to draw a line at some fraction of Indian heritage and allow people only on one side of the line to get free medical care.

John L. Mittern, executive director of the Denver-based National Indian Health Board, which acts as a watchdog over the IHS, said the decision about who is an Indian should be left to the tribes.

"Being an Indian is in your heart, how you feel," he said. "It's being a citizen of an Indian tribe. . . I know some who are 1/256th or 1/3126th who are more Indian than those with full blood."

THE WASHINGTON POST
Aug. 8, 1982

PHYSICIAN SHORTAGE
ABERDEEN AREA

- 18 Aberdeen MD vacancies
- 4 Fort Yates - Five (5) slots available
- 4 Eagle Butte - No permanent
- 4 Rosebud - Seven (7) slots
 - Pine Ridge - Filled seven (7) out of seven (7)
 - Turtle Mountain - Six (6) slots filled seven (7) on board
- 2 Fort Berthold - Two (2) slots Two (2) vacancies
- 1 Fort Totten - Two (2) slots One (1) vacancy
 - Sisseton - Three (3) filled presently (One(1) vacancy in July)
- 1 Wagner - Three (3) slots One (1) vacancy (Two(2) vacancies in July)
- 1 Winnebago - Three (3) and One (1) field health (Two (2) vacancies in July)
 - (638) 1 vacancy
- Rapid City - Seven (7) slots
- 1 Chamberlain (Lower Brule) Three (3) slots
 - (Fort Thompson) Two (2) filled One (1) vacant & One (1) more in future

NURSING VACANCIES

Twenty-seven (27) nursing vacancies

2/18/83

INSTITUTIONS WHERE PROFESSIONAL DEGREES WERE
EARNED BY INMED PROFESSIONALS (1973-1982)

<u>Medical Schools</u>	<u>Number of Graduates</u>
University of Alabama	4
University of Arizona	1
University of California (Davis)	1
University of Colorado	5
University of North Dakota	2
University of Oklahoma	3
Harvard University	1
University of Kansas	1
Medical College of Wisconsin - Milwaukee	1
Mount Sinai	1
University of New York (Buffalo)	1
University of Texas - Southwestern (Dallas)	1
Tufts University	1
University of Utah	1
University of Washington	1
Washington University - (St. Louis)	1
Oral Roberts University	1
George Washington University	1
John Hopkins School of Medicine	1
Sub Total	<u>29</u>
<u>Dental School</u>	
Creighton University	<u>1</u>
Sub Total	<u>1</u>
<u>Masters in Public Health</u>	
University of California - Berkeley	<u>1</u>
Sub Total	<u>1</u>
<u>Nursing (B.S.)</u>	
College of Nursing, University of North Dakota	<u>2</u>
Sub Total	<u>2</u>
TOTAL	33

Updated: December 30, 1982

INMED PROGRAM
Academic Program Participants
1973 - 1982

One hundred and sixty-nine college undergraduate students have enrolled at the University of North Dakota as participants of INMED. Following is a breakdown of student accomplishments and the "spin-off" effect INMED has had on students who left the Program for personal, academic, or financial reasons.

CATEGORY OF PARTICIPANTS		PARTICIPANT NUMBERS		
Students Who Were Continued As Participants of INMED		Direct	Ind.	Total
1.	Students presently pursuing undergraduate degrees/ pre-medical school requirements.	32	6	38
2.	Students presently pursuing a health professional degree (NODVOPP).	22	6	28
3.	Students who have completed a health professions degree:	<u>33</u>	—	<u>33</u>
	Totals	87	12	99
	Doctors of Medicine (M.D.)	29		
	Masters in Public Health (Ph.D)	1		
	Doctor of Dental Surgery (D.D.S.)	1		
	Registered Nurse (B.S.N.)	2		
Students Who Were Dismissed/Withdrew As Participants of INMED				
4.	Students presently pursuing an undergraduate pre-health or math/science degree.	18		
5.	Students who have completed a health or math/science degree.	4		
6.	Students who are presently working in the health/health related field but did not complete the degree they were pursuing with INMED.	17		
7.	Students who are presently pursuing a non-health degree.	5		
8.	Students who have completed a non-health degree.	3		
9.	Students who are presently working in a non-health/ health-related field but did not complete a degree.	14		
10.	Students presently seeking employment and have not completed a degree.	-		
11.	Students unable to be tracked at the present time.	8		
	Total	169		

	<u>Number</u>	<u>Percentage</u>
The number and percentage of participants who have been tracked that are associated with a health or math/science related area; either as students or as working personnel. (1+2+3+4+5+6=T)	138	82%
The number and percentage of participants who have been tracked that are associated with a non-health career; either as students or as working personnel. (7+8+9+10)	23	17%
The number and percentage of participants who are not associated with a health, or other, career; either as students or as working personnel. (11)	8	4%
	<u>169</u>	<u>100.0</u>

*Participant numbers reflect enrollment of the regular academic programs only, and discludes Summer Institute and particum participants.

Kerry Hartman/Counselor-Research
December 30, 1982

KH/ab

TOTAL NUMBER OF PARTICIPANTS
INMED 1982-1983

- 16 Freshman - nine (9) not receiving IHS scholarships
- 8 Sophomores - three (3) not receiving IHS scholarships
- 7 Juniors - none not receiving IHS scholarships
- 12 Seniors - one (1) not receiving IHS scholarship
- 12 Special graduates - three (3) not receiving IHS scholarships
- 5 First year medical students - none not receiving IHS scholarships
- 8 Second year medical students - three (3) not receiving IHS scholarships
- 4 Third year medical students - Transferred to other schools from UND
none not receiving IHS scholarships
- 6 Fourth year medical students - Transferred to other schools from UND
three (3) not receiving IHS scholarships
- 14 Residents
- 15 M.D.'s who have finished residency (11 are working or have worked with
Indian Health Service or a place
with an IHS contract)
- 5 Graduated - Allied Health Professions

Financial Aids;

- * INMED received fifty-two (52) I.H.S. scholarships for FY'82. Supplemental funding for eligible I.H.S. funded students and total funding for all other students came from Title IV, Pell Grants, B.I.A., Tribal scholarships, Loans, Workstudy, and other miscellaneous sources.

Prepared by: Kerry Hartman
Counselor/Research Analyst
Date: 2/15/83

KH/ab

INSET CATEGORY	FY - 1982		Change from FY - 1981		Increase/Decrease	
	Sub Cost	Line Item	Sub Cost	Line Item	Sub Cost	Line Item
Section 102 - Health Prof. Recruitment						
(a) Personnel	\$118,363.00			\$130,137.00		\$(-) 11,774.00
(b) Fringe Benefits	21,602.00			21,304.00		(+) 298.00
(c) Travel	10,000.00			25,150.00		(-) 15,150.00
(d) Equipment	-0-			29,590.00		(-) 29,590.00
(e) Supplies	3,470.00			10,000.00		(-) 4,330.00
(f) Other	29,750.00			103,075.00		(-) 73,325.00
1. Consultants	\$ 2,000.00		\$ 3,000.00		\$(-) 1,000.00	
2. Telephone	3,500.00		6,000.00		(-) 2,500.00	
3. Postage	3,250.00		2,000.00		(+) 1,250.00	
4. Learning Resource Center	750.00		2,075.00		(-) 1,325.00	
5. Publications & Printing	3,000.00		11,500.00		(-) 8,500.00	
6. NCAT, NISE, Fees	-0-		2,500.00		(-) 2,500.00	
7. Health Prof. Seminar	-0-		15,000.00		(-) 15,000.00	
8. Program Advocates Trng.	-0-		34,000.00		(-) 34,000.00	
9. Summer Inst.-College Prof.	-0-		9,000.00		(-) 9,000.00	
10. S.I. - Jr. High Sch. Prof.	15,250.00		18,000.00		(-) 2,750.00	
(g) Direct Charges Totals	185,185.00		319,256.00		(-) 134,071.00	
(h) Indirect Charges Totals	14,815.00		21,014.00		(-) 6,199.00	
TOTALS	\$200,000.00		\$340,270.00		\$(-) 140,270.00	
Section 103 - Health Prof. Prep. Scholarship						
Section 104 - Health Prof. Scholarship						
Section 105 - Externships						
(a) Health Professions Seminar	\$17,100.00			-0-		\$(-) 18,468.00
Indirect Charges Total	1,368.00			-0-		(+) 33,600.00
(b) Program Advocates Training	35,740.00			-0-		(+) 25,547.00
Direct Charges Total	2,860.00			-0-		(+) 17,648.00
(c) Summer Inst. - College Program	22,728.00			10,000.00		(-) 107,872.00
Direct Charges Total	1,819.00					(-) 118,879.00
(d) Externship Program	25,600.00					(-) 107,872.00
Direct Charges Total	2,048.00					(-) 118,879.00
(e) Student Scholarships						(-) 197 overall decrease
GRAND TOTALS						
funded under other sections of the						
overall Title I budget for FY - 1983						

Senator ANDREWS. Our next group is five students. Lewis, congratulations.

Mr. GILBERT. Thank you, sir.

Senator ANDREWS. Having a medical student in the family myself I know how significant your achievement is. It is a testimony to your intelligence and of course your ability but also hopefully to the teaching and guidance that you get in the medical school. We are privileged to have you here and let me assure you that your entire statement will appear in the record as if having been given in total. You can summarize it in any way you want to and have your fellow students interact and add for the record whatever comments they might have.

STATEMENT OF LEWIS GILBERT. MEDICAL STUDENT, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE

Mr. GILBERT. I am a Gros Ventre Indian from the Fort Belknap Indian Reservation. I was born in the Indian Health Service hospital as a matter of fact. I have several reasons for believing that INMED should stay in existence.

First of all it is very difficult to come from a reservation and from a rural setting into the city where you hardly know anyone and many times the people you do meet do not understand the cultural context from whence you come.

Coming from a reservation is a unique problem to Indians. There is a lot of cultural shock there. As any ethnic group, we have our own values and ideas and we would like these beliefs, ideas, views, et cetera, to remain intact. If they stay intact we do not lose sight of our goal which is mainly to serve Indian people.

INMED allows us to have the continuity with our homes and traditions and values by serving as sort of a home away from home. Also, INMED has given us an identity, not only here on campus, but also nationally. I met somebody the other day from Arizona who heard of the INMED program through hearsay. He had no direct contact himself but it was good hearsay. We have a fairly good reputation around the country. I have met people from places other than Arizona who spoke well of INMED.

INMED supplies the Indian students with many support services such as tutoring and counseling by people who have had experience in this field. I think they mold their services to us strictly. They know these problems. They have been dealing with these problems now for years and we tend to have the same kind of problems over and over and we are quite indefinite and helpless to these things.

A lot of this is necessary because Indian people do not usually have the best of education. High school educations are usually somewhat lacking in preparation for college work. I, myself, graduated in 1959. I am older than a lot of the professors I had in school. I could not read when I got out of high school. It took probably about 2 or 3 years before I finally got mad and frustrated and decided I was going to learn how to read. I finally went to college. I had to take bonehead English. I had to take bonehead math. I took bonehead algebra three times before I passed it. That is equivalent to high school algebra. Now I have tutored a lot of students myself, a lot of INMED students, and

I think I have done a fairly successful job of this when other people could not. I understand the frustrations and the hard work and the encouragement you need to do so, a bootstrap operation type of thing. I knew oftentimes exactly the concepts they would get hung up on because I went through this process myself.

Anyway, it takes a lot of work and a lot of encouragement and things like that which I found through INMED, other INMED students who are now doctors and things, they helped me along, too, so it is not just the staff.

We are congregated here in one area through INMED which allows the students to help each other. If we did not have INMED, this kind of support which actually nobody has to pay for, the interstudent support and tutoring and things that go on, that stuff would be lost, not to mention the other things that INMED does for us.

If we turn students loose on these national scholarships without the support of something like INMED, I think a lot of these guys are going to be casualties because it is—well, we just have a lot of practical problems. I think your money is going to be better spent if you support something like INMED because of these casualties. It would be much worse to have somebody go through 4 years of school than the 5 it takes and send somebody through and have them drop out and have nothing to show for your money. Their training would be incomplete and probably not serve a needed purpose.

INMED itself continues to serve as a reminder to Indian students that they can perform at an adequate level in college and as professional students. I myself had many doubts whether I would ever get through medical school, but there is, you know, 30 some doctors now that INMED has produced. You can also look forward to say—I know a lot of these doctors personally. They were going through when I started and I see that they made it through. It is kind of nice when you can say, "Well, they did it. I can do it," because you know they are basically the same type of people.

Now I have no financial obligations to return to the reservation. I did not sign a 4-year contract because in there it said I can virtually be shipped anywhere in the United States that they want me to work. So, through borrowing money, through student loans, through title IV, I managed to get through financially.

I did this because I wanted to go back to the reservation. I did not want to wind up down in Alabama somewhere in a city. I wanted to go back home. Specifically, that has been my desire since I came here and as a matter of fact when I interviewed for medical school I told them exactly what I wanted to do. I wanted to go through an internship and go back to the reservation and work.

Now I have to do 1 more year of training. Then I am going back home and I want to serve as some kind of role model for young Indian people there to come into medicine. I want to have a place that I can tell them to go, you know. You go to INMED. I want to have a place where I can send them that I know that they will have some assurance of having support and encouragement and the feeling of belonging that I have received with the INMED program. If INMED is no longer in existence, I am going to be kind of hesitant in certain ways to encourage these people to go out and tackle this endeavor because

I really do not want to set somebody up for something they cannot handle.

Thank you for letting me testify.

Senator ANDREWS. Well, Lewis, that is an excellent statement. Let me ask you a couple of personal questions that I think we can use as role models when we are trying to justify the program.

You said you graduated from high school in 1959 and had to take all the remedial courses.

Mr. GILBERT. Yes.

Senator ANDREWS. Where did you do that? Where did you take the remedial courses and when?

Mr. GILBERT. Well, I started out at the university.

Senator ANDREWS. Here at the University of North Dakota or down south?

Mr. GILBERT. I took——

Senator ANDREWS. You were a catch-as-catch-can student. You went to school for a while and then you went back and came in and tried?

Mr. GILBERT. Yes.

Senator ANDREWS. When did you first make contact with INMED or when did INMED first make contact with you?

Mr. GILBERT. Well, I was working for the State of Montana running a program for the disabled people of the reservation.

Senator ANDREWS. As a college graduate?

Mr. GILBERT. Yes. I was in psychology before. I started out in geology but I could not handle mathematics and organic chemistry which I wound up taking in medical school anyway and I switched into psychology. Anyway, I had to take all these courses. It scared me to death. I tell you it is kind of a harrowing experience to go back to all of those.

Senator ANDREWS. But without INMED you would never be where you are today?

Mr. GILBERT. I would never have come to medical school I do not think.

Senator ANDREWS. Did they seek you out or had you heard of them?

Mr. GILBERT. First of all, I got interested in going to medical school because I am interested in the subject matter particularly, but also, back home at the Indian Health Service, there was a constant influx and outflux of doctors and I saw the need for somebody to stay there. I think the lack of continuity and lack of health care by Indian Health Services is quite a detriment to Indian health.

Senator ANDREWS. With your knowledge of Indian people and your own personal experience, the observations you made before you went to medical school in working on the Indian reservation, do you believe that a program such as INMED is the best possible way to get the continuity of medical service on the reservation?

Mr. GILBERT. I believe so. We need Indian physicians pretty bad, not only so that they will stay but also, I have seen non-Indian doctors come through Indian Health Service. One was from Jamaica. Obviously quite a cultural gap there.

Senator ANDREWS. How did he like the Montana winter?

Mr. GILBERT. Well, he did not stay very long. He probably went back to Jamaica where it was nice and warm.

I have seen doctors from back East who were fairly well-meaning people but totally misunderstanding of Indian people. My first clinical rotation was when I went back home and there was a woman who came in one day who was in early heart failure. Usually you get backed up in the clinic with emergencies and things like this.

Anyway, it came around noon and all the doctors went home. Well, she sat there all morning and Indian people sometimes do not care to wait too long and so, she went out, got in the car and was going to leave.

Well, I went out after her and I said, "Come on back in." "We want to see you." She said, "No, I don't want to be seen here. The doctors don't want to see me." Well, I sat there and I finally persuaded her to come back in and I did a physical exam that afternoon and when the doctors came back they treated her heart failure. She would have gone home with that.

Senator ANDREWS. But she had the confidence in you because you were someone that she could perceive as a personal friend.

Mr. GILBERT. Yes.

Another example of how these things can get in the way happened when I was working down in the Fargo VA Hospital last year and a 57-year-old Indian gentleman came in with acute abdominal pain which is a medical emergency. The resident went in to see him. The resident could not make heads or tails out of the history and he knew that I was Indian and he says, "You go in and see what you can find out," so I went in and I had no problem at all.

And this was probably the first really striking case of this gulf that comes between cultures in the medical sphere. He was, of course, talking and using gestures and a lot of incomplete sentences that Indian people use sometimes and if you have a common experience with these people you can fill in the blanks where this other doctor could not do this. I came out of there with a totally coherent history.

Senator ANDREWS. That shows the system works.

Mr. GILBERT. Yes. It made quite an impression on me.

[The prepared statement follows:]

PREPARED STATEMENT OF LEWIS GILBERT, MEDICAL STUDENT, UNIVERSITY
OF NORTH DAKOTA

My name is Lewis Gilbert and I am a Gros Ventre from the Fort Belknap reservation. I have several reasons for believing that INMED should stay in existence. First of all it's difficult to come from a reservation in the country to a city where you know hardly anyone and the people you do meet many times do not understand the cultural context from which you have come. I see INMED as giving us a "cultural context" in which to operate and to have available people who understand our types of problems that we as Indian people tend to have, which I don't really think anyone else could understand. This is because just as any other ethnic group has their own values and views, we need these beliefs and values intact and supported so we do not lose sight of our goals to serve Indian people. I think INMED allows us to have continuity with our homes, traditions, and values, by serving as a home away from home. INMED gives us an identity, not only here on campus, but also nationally. The other day I met someone from Arizona who is familiar with the INMED Program through hearsay and the hearsay was "good". Another thing is that INMED supplies the Indian students with many support services, such as tutors, counseling, etc. . . They can mold their services strictly to us. You may ask, well why is this necessary? Indian people generally don't have the best education at the high school

level and are usually poorly prepared for college work. I myself have tutored several INMED students, when I think sometimes other people could not have, because I know the frustration and the difficulties and the hard work that it takes and the encouragement one needs to get this basic background that makes you an adequate performer in college level courses. It is precisely that kind of support I think that students will lose if INMED goes out of existence. Many students come here and feel they can't make it off of the reservation. If they were turned loose on a national scholarship somewhere, I think they would have a rough time. INMED continues to serve as a reminder to Indian students that they form an adequate level in college and professional school. I myself have had many doubts on whether I would get through school, medical school being very difficult at best, but I see those who have gone before me and it's encouraging to know people much like yourself went through it and did a good job. There's nothing like the 30 doctors or so that INMED has not graduated from medical school to do just that.

I have no financial obligation to return to my reservation and work for the Indian Health Service; that is something I desire to do and to put back in a little something for the many things I have gotten from INMED. Now after my internship, when I go home, I hope to serve as some kind of role model to young Indian people, as the other 30 INMED doctors have served for me. Where am I going to tell these students they can go? How can I give them any assurance that they will receive the same kind of support, encouragement, and feeling of belonging that I have received from the INMED Program, if INMED is no longer in existence? I know INMED, I trust INMED, and INMED is a quality program. If INMED is here I can go home and give the proper encouragement to people without feeling like I'm setting them up for something that they can't handle. Thank you for letting me testify before you.

Senator ANDREWS. Well, Joe and Rodney, you are from North Dakota.

Mr. LUGER. Yes.

Senator ANDREWS. Good. What would you have to add? Would you have had the possibility of being in medical school if it were not for INMED?

STATEMENT OF JOSEPH LUGER, JR., MEDICAL STUDENT

Mr. LUGER. Well, when I first joined the program, I was in the North Dakota medical technology program here and I was making it through on Pell grants and BIA. About the third year on, my twin brother there was in INMED and he said it was possible to apply to INMED to be a medical technologist, so I did and I graduated from INMED as the first medical technologist in the program.

But as far as going on to medical school, it was kind of in the back of my mind but I was encouraged and influenced by my brother and all the people in INMED to go on to medical school so—

Senator ANDREWS. But INMED was helping you with medical technology as well.

Mr. LUGER. Yes, sir.

Senator ANDREWS. Does INMED provide any form of retraining for students who might be unsuccessful in medical school? Or once they get you into medical school, you are successful?

Mr. LUGER. Well, they do everything that is possible to keep you in medical school. But, if you do not make it through, I have known several cases that they have had career counseling and brought them into other areas. You do the best you can with what you have.

Senator ANDREWS. And if INMED funds were cut or eliminated what would happen to you?

Mr. LUGER. I am already there and I am reasonably sure I am going to make it through, so I would probably go and make all the loans I could from every different bank that I possibly could and I think I would make it through.

But, if INMED was not there, I do not believe I would have got started on it.

Senator ANDREWS. You would not have gone through in the first place, but now that you are there with a sound academic record, now you could turn to the normal credit sort of thing?

Mr. LUGER. Yes, I could.

Senator ANDREWS. Where are you practicing now?

Mr. LUGER. I want to go back to Belcourt to practice. They have an adequate supply of doctors there. Right now it is probably one of the best facilities I have seen, but there are other facilities like Fort Yates and Fort Berthold.

Senator ANDREWS. Do you use the Rolla hospital there?

Mr. LUGER. Do I?

Senator ANDREWS. Would you when you went back to Belcourt? Would you use the hospital at Rolla?

Mr. LUGER. I do not believe so. I would keep all the patients at Belcourt.

I have found that there is a little bit of mistrust and sometimes the people there have a mistrust actually of their own facility. Some of the people actually go to surrounding communities for their health care when I, personally, believe that they are not getting any better health care at Rolla or—

Senator ANDREWS. The reason I asked that question was rather personal because I was on the subcommittee years ago in the House that funded the package that made possible the hospital in Rolla. One of the reasons that I used to justify that hospital and the one that I think that got the funds for the hospital in Rolla was that the hospital was going to be a training site for Indian young men and women in nursing and to train them as paramedical types. That is really the justification I used and that is why you sparked my remembrance of that when you said, "I'm going back to Belcourt but I am going to practice in the hospital at Belcourt," In essence the hospital at Rolla is sort of out of the sphere.

Now we spent several million dollars as I recall to build that hospital because of its unique location in proximity to the Turtle Mountain Reservation and the justification I used was that it would be a training center for the Indian people. Obviously something happened between then and now.

Mr. LUGER. As far as I know there is a cooperative program between the hospitals at Rolla, Belcourt, and Rolette, an ongoing paramedic training program. I know the person who is in charge of that. They have this cooperation between the three or four hospitals in the area to train paramedics and ambulance personnel.

Senator ANDREWS. But principally the health care of the people on the Turtle Mountain Reservation is met in the hospital in Belcourt.

Mr. LUGER. I would believe so even though in the surrounding area, like Fort Berthold and Fort Yates they still have a tremendous need for medical technologists and laboratory personnel.

Manny was describing what happened when Emory [Keoke] went to Fort Berthold. Untrained, he received a few weeks of on-the-job training and then he was essentially the only lab tech they had there for awhile. Sometimes, when the hospitals at Fort Yates or Sisseton need a person, anybody they think can help them out in the lab, they call INMED and ask for personnel.

Senator ANDREWS. Kind of like a pharmacist's mate that did the appendectomy on the submarine. He did it because he was the only one who was there and was the best that was available. It is not good medical practice.

STATEMENT OF LARRY DAUPHINAIS, MEDICAL STUDENT

Mr. DAUPHINAIS. I am Larry Dauphinais and I am from Belcourt. I have a family of five and if the funding were cut for INMED, or health medical scholarships, I would definitely have to drop out, I am sure, at this time.

I lived about 15 years on the reservation and I went to Indian mission schools. Our family was very poor and it was a real adjustment coming to medical school here, coming from the background that I came from. A lot of the students here in medical school have dads who are pharmacists and doctors and so on and so forth and it was a real adjustment for me. Without lots of support and encouragement of the program I do not think I would have made it through the first year so I am really grateful that there is a program available here.

Senator ANDREWS. The program is far more than just dollars.

Mr. DAUPHINAIS. Yes. Definitely.

Senator ANDREWS. Thank you very much. Do you have a comment?

STATEMENT OF EMORY KEOKE, MEDICAL STUDENT

Mr. KEOKE. My name is Emory Keoke. I am an undergraduate student here. I am 36 years old.

To me INMED has been one of the most vital programs I have ever seen and one of the most practical. If, at some point, we are to assume responsibility for our own affairs, INMED here, I think, is one of the most practical ways that that is going to be achieved and it would be sad to have the funding reduced at this point.

I guess it would not be any less typical than any government program that the funding is cut after 3, 5, or 6 years and you do not have any time to see the results.

Between 1971 and 1973, I spent 2 years receiving my additional training through the State hospital. I returned to the Standing Rock Reservation—I am an enrolled member down there—to work in the alcoholism program and after I got to work for a while I became interested in the health field because obviously it lacked quite a bit.

So after 4 or 5 months, I went to the public health medical social worker there and asked him, I said, "I am really interested in the health field. Can you suggest some ways that I can begin to find out about it?" Then he said, "It is too difficult, you probably would not make it."

And you know the sad thing is, sir, that from my upbringing, everything I had learned, my training, everything I had learned from the mission schools, boarding school, whatever, I believed him and that is scary. I believed him that I could not make it.

Three years ago, almost to the day, I ran into Liz Demaray, the assistant director here and I subsequently asked her what she was doing and she informed me of this program, the INMED program and I told her that I was interested and she encouraged me to try. I am sure she figured, well, you know, I might not make it and that is what she kind of said, "If you qualify, then we will accept it." But she gave encouragement to me, and this is the difference between an Indian and a non-Indian. You know, they encourage me that I do have some capabilities that even I cannot see, so I think this is very important for other Indian people. Myself, I think it is very, very important.

Lewie here has tutored me many, many times in my inorganic chemistry, and not only Rodney but a lot of the medical students come by. We stop them. They do not have all the time in the world but they will stop and tutor us when we have questions with particular problems, math problems, whatever they may be, inform us on a lot of other stuff and to me this is so vital because I needed a role model to know that I could make it, to actually see that there were Indians doing it. INMED is such a unique program because there are always some Indians a grade or two behind me, or a grade or two ahead of me and they are in medical school. Those role models are so very, very vital for my own mental health because the work does get difficult sometimes, a lot of memory situations, a lot of time-consuming study and sometimes the support I can get from the upper-classman is so very, very vital to my own mental health.

I think that many of the students don't even consider the INMED administration office as an administrative function. It is like a part of a family. We have many, many Indians and many different tribes in the Indian program and I have never seen the cohesiveness, or the loyalty in any other program anywhere else I have been. I have never seen loyalty like this.

People here are pretty much the cream of the crop I would say. I do not know how I got accepted into this thing, being older and everything else, but I think I have a good chance to learn from it. I also had to take the bonehead math and there is even a bonehead biology and I took that as well.

A couple of years ago, I had been with INMED for 1 year, sir. I did an externship up at Fort Berthold and as it was noted earlier, the medical technician left after a few weeks of training. I had been in the INMED program for 1 year at that point. I was given the sole responsibility for the clinic there and I know what fear is. I was scared. That is an awful lot of responsibility, knowing that I was not qualified so I told them that, "I am doing it under protest. I realize I am not qualified," and they said, "There is no one. You are it." I was it.

So, in the process of doing lab work you have urine samples which you have to analyze, and you have to centrifuge them down. You do your dip check for protein sugar and a lot of other tests, whatever the

doctors order; hematology, chemistry, the hematocrit, the blood work, the CV's, the blood count, whatever. Whatever the answer, these tests are really involved.

At least, the system that we have at the reservation is very archaic. We have machines and they are timed by hand to run all these tests, the PT, the protein, and the platelet counts. We have to do this platelet counts by hand and it is very time consuming to look through a microscope and count platelets. If we get about three or four platelet counts we generally have to reserve those until the end of the day because it is so time consuming and you go almost half blind looking through the microscope to count those little suckers, you know. After a couple of them it is really hard to see.

When I was in my sophomore year we had a high cell counter. Ours was broken. They had one broken in Fort Totten. I was working under a gentleman by the name of Wayne White Eagle, a gentleman who also came up the hard way. He was an older student, went through technical institute and was kind of self-made. He did a lot of studies on his own and was responsible for the training. This guy can be a really valuable asset but is not eligible because of the funding or whatever to become an INMED student. I think Indian Health Service would have somebody very valuable if he could train two, three people to do X-ray and he can. That is a heck of a mind twist.

I get kind of involved because I am Indian. These are my people and I care that they should have the best of whatever it is as any other human being. You know, we should be the best that we can for them.

Some of the other problems that I have seen have to do with getting medicine or supplies that are needed. When we were working with Dr. Gray Eyes, a surgeon up there who is no longer here in Indian Health Service, we started making a list of the drugs to order, and we sent a list down to Aberdeen so that they could send us what we needed, but instead of getting what we asked for, we got whatever they had available or whatever they thought we needed, or they didn't come at all. So you have got those kind of difficulties to work with.

We worked at Fort Berthold Reservation with hematocrit readers. Now hematocrit, I do not know if you are familiar with it. You poke somebody's finger. You draw some blood. You put it in the centrifuge and your centrifuge goes down and up to separate elements, but there is a level you can see.

And we had one hematocrit reader where it had a shot where you put it on there. It is a round one. The back is graduated in increments on a circular base so you put it in a little groove and you move it around so you can get a reading off it. That was broken. He had to glue it together, tape it together and glue it. That throws the reading off.

The hematocrit readers are plastic. You have to hold the thing steady and you have a capillary tube which is really time consuming. On the reservation you do not have that much time and, you know, you order it. It just does not come.

We had a hematology tray in Fort Berthold and New Town clinic when Lois Steele and I spent a couple days with White Shield. There were several there, too, not just one or two or three or four examina-

tion trays and Lois is going through these and she's got lab work orders. In a cardboard box I have lancets, I have my swabs, my alcohol rubs, I have my syringes, and I have my needles. I have all of my test tubes because I have test tubes for the blood, for the different types of whatever tests the doctor orders. They have different test tubes with a rubber stopper and by looking at it you can tell what it is you need to do, so I am going through there and the only thing is, I am carrying stuff in this cardboard box. It makes it really difficult on the patients because there you have to label all the test tubes and set them up, but the only thing I could do is to come up with a cardboard box I grabbed with test tubes. For somebody younger or somebody older, it is extremely painful if I have to get several test tubes of blood, and keep that syringe in the arm all the time, especially if I have to start reaching around grabbing the test tubes and if I cannot see it I reach in there, I get the wrong test tube, it means I have to put it back, cause a little more pain, a little more inconvenience to that patient which I do not think they deserve.

And so, just not having the proper equipment causes a great deal of pain personally to the individual patients which I think they do not deserve but that is the type of equipment that we have to work with.

Senator ANDREWS. Not only that, but you might not get the right reading and it might cost more to save a couple of bucks up front. You might spend \$12,000 down the line to take care of the much more serious problem that that patient has because somebody did not get the nail in the horseshoe in the first place.

Mr. KEOKE. Exactly.

Senator ANDREWS. As the old story goes, you make an excellent case. It is most helpful to us.

You know, the problem that we have is that the people in the Office of Management and Budget have never been on a reservation. They do not really know what the need is out there. They look down their own block and their own delightful suburb of Washington and they think everything is fine with the doctor and his Mercedes on every block. No problem. That is not the real world and that is why these hearings are most helpful because you say it so well, expressing the need.

Mr. KEOKE. One other thing I would like to say. Everything I love and everything I will hold to is on the reservation. My parents and my little sister are buried there. That is where I am going to be buried. I have a vested interest and it seems only practical, and I consider myself pragmatic, that if I am going to live the rest of my days there, would it not make sense that I have some skills that can alleviate some of the problems? I mean that is just how I think about it. I do not know how the Government would see that.

Senator ANDREWS. Well, the Government ought to see it. It is fortunate that we have someone who has the ability to absorb the training so that he or she can have the skills to go back and do the work that is so much needed. That is really the way this country was built so we must do more and that is why we are having these hearings.

Do you have something to add, Mr. Bellinger?

STATEMENT OF TOM BELLINGER, MEDICAL STUDENT

Mr. BELLINGER. Yes. My name is Tom Bellinger and I am from Alaska originally and my mother is an Eskimo from the Yukon area near the Bering Sea.

Senator ANDREWS. The committee is holding hearings up in Alaska tomorrow as a matter of fact.

Mr. BELLINGER. I would just like to say that without INMED I think that it would have been difficult, if not impossible, for me to make it just because of the attitude that builds up over time when you are in undergraduate school that everything is really impossible; that there are these insurmountable barriers. You think that you have to be a genius and well educated, and have well educated parents. I think that INMED has allowed us to break through that barrier.

INMED has also made it affordable here. The program afforded me tuition and travel, books and monthly stipends for essentials—food and rent—and for the medical education.

I think too that INMED has supplied something very important as far as pure support for the people that are in INMED. I am ending my sophomore year now and I feel that it was really essential to have the other people, the other sophomores in INMED, to help me sort out what was important and to just have a general discussion amongst ourselves about medical topics and about the emotional impact of going through such rigorous training.

I think, too, we have had good counseling. We have had test files. We have a library at INMED that has books that are really current and important. They are sometimes hard to find elsewhere. We have had study tips and we have been able, through INMED, to successfully transfer to other medical schools so that has been a very good process from beginning to end here.

I also had an opportunity to do a clerkship in Belcourt for 3 weeks and I just recently finished that.

I feel that one of the most important things, as an Indian student, is to have the proper attitude and the right place to work, being on a reservation. For me it will be working in an Alaskan village, but understanding the minds of the people that you are trying to treat there and working with another fellow INMED student there was really helpful.

I talked extensively with a physician while we drove to Fort Totten for some temporary care on a Friday afternoon. The doctor is from an Ivy League school. She, the doctor, seemed to want a peer group of physicians that are of very high rank and felt very distressed about being isolated in a small area such as Belcourt as compared to, say New York or Philadelphia.

I think that what I can offer as a physician is more understanding of the people that are so-called chronic health abusers or people that are angry at physicians for not being cured. I think that the qualities that you have to have are understanding and empathy with a patient and understanding of their cultural differences and slightly different attitudes.

I find that it is easy for the physician that I was working with to talk way over the heads of the people that they were treating as far as drug therapy and diagnosis. A lot of times I saw bewilderment on the faces of people that were talked to and I thought that was something that could be overcome by the understanding of the culture of the people that were there and their general education level.

I have found that there is sometimes poor interaction between the physicians and the patients there because of problems with communication. It was really distressing for me to hear one of the physicians say that it was a typical Belcourt day or a typical Belcourt mentality that a 16-year-old would be pregnant and to hear the physician kind of labeling the whole reservation and all the people there as such. It was really distressing to hear her say that she had to constantly work with poor and stupid people. I was really offended by that and I just hope that it can be redressed by people understanding what the reservation is before they ever work there. Not expecting the world out of people as far as medical knowledge and compliance, but to be able to teach them because I firmly believe that the physician is not for the healthy but for the sick.

I know that in Belcourt four out of the six physicians that are working there now will be leaving by the end of next summer. I find that the turnover destroys continuity in health care and patient education and I feel that a commitment to the reservation and an understanding of the people from having relatives that live on a reservation or in village settings makes it easier to be a physician at their level.

I guess the goal for me is to see INMED continuously recruiting American Indians and retaining them through medical school. I know that physicianship for anybody is a long process and I think especially through INMED we can get some of the help that is needed, emotional support and academic support in the funding.

I know, personally, that there are only two Eskimo physicians in the whole country of the United States. I would like to see that change. I feel committed to working back in Alaska for the village. I have had experience there before, an IHS clinic for 2½ months on an island in the Bering Sea. I feel at home there and I feel that an understanding of the people and their attitudes as a native American will help me be a better physician for them.

I feel that the medical education I got here is very good and very applicable and I feel that it has to be open to other Indian students through Inmed.

Senator ANDREWS. Thank you all for your statements.

Mr. LUGER. Thank you for the opportunity.

Mr. KEOKE. Thank you for the opportunity.

Mr. LARSEN. Thank you for the opportunity for us to testify.

Senator ANDREWS. Thank you for your help.

Our next witnesses are Matthew Mason, Fort Berthold Tribal Business Council; Carl McKay, former tribal chairman of the Devil's Lake Sioux Tribe; Pat McLaughlin of the Standing Rock Sioux Tribe; and Richard LaFromboise from the Turtle Mountain Band of Chippewa Indians.

Matthew, are you going to lead off?

Mr. MASON. OK.

Senator ANDREWS. Your name is first on the list of four. Let me assure you that any prepared statement you have will appear in full in the record and that you can summarize it. Give us as much time as possible to answer some questions for the record. That will be helpful.

**STATEMENT OF MATTHEW MASON, SECRETARY, FORT
BERTHOLD TRIBAL BUSINESS COUNCIL**

Mr. MASON. OK. Thank you, Senator Andrews.

First of all my name is Matt Mason. I am secretary of the tribal business council for the reservation and our problems are the same as the rest of the reservations in the State of North Dakota, and in the Aberdeen area, but ours are more serious than the rest of the reservations.

As you know, the Government has destroyed our lands with the Garrison Dam, thereby cutting communications off to where we have five segments and it is pretty hard to communicate the way it is now. We have an area down there, the south segment, which is a hundred miles away from public health and the people that stay there have a difficult time getting to the public health clinic in New Town. Some of the enrolled members who get sick or have emergency calls cannot reach that place. They have to go to a local hospital which may be about 50 miles.

When they get there they get treated, and maybe they have to stay there 1 week and then the bill goes into public health and public health turns around and tells them: "We did not refer that patient to that hospital, therefore we cannot pay that bill." Even though it was an emergency.

Our elders, when they get sick, do not have time to travel clear around the Garrison Dam—

Senator ANDREWS. In other words, you are telling me that the Indian Health Service tells your people, if they have a medical emergency and they go to the nearest hospital, which is 50 miles—

Mr. MASON. No. They do not tell them. If it is an emergency they go on their own because they know they are not going to make it.

Senator ANDREWS. No, no. Let me rephrase my statement. If one of your Indian people has an emergency and he goes to the nearest hospital, which is 50 miles away, and he is there for 1 week to resolve his emergency and his life is saved, when the bill comes in, Indian Health Service says they will not pay it because they wanted him to drive around the reservoir and over to an Indian Health Service station to be looked at before he goes to the hospital.

Mr. MASON. That is absolutely correct, Senator Andrews.

Senator ANDREWS. How many miles would they have to drive to the IHS facility?

Mr. MASON. From the south segment, approximately 144 miles.

Senator ANDREWS. So the Indian Health Service is telling your people that they have to drive 144 miles to go see one of them and then go back 50 miles to the hospital?

Mr. MASON. That is correct.

Senator ANDREWS. And these are relatively sane people that are saying this?

Mr. MASON. Yes. Government workers.

Senator ANDREWS. Yes. And what Indian Health Service says then is that in the case of any emergency appendectomy, that any Indian patient under IHS jurisdiction will not have their hospital care taken care of if they do not drive 144 miles, first to report to IHS. Are they open all the time?

Mr. MASON. No, sir.

Senator ANDREWS. Let us say you need an appendectomy. You the 144 miles to report to who ever it is. They would not be there on a Saturday or a Sunday, would they?

Mr. MASON. That is true.

Senator ANDREWS. And if you arrived there during business hours, how long would you have to wait?

Mr. MASON. Oh, that varies. It seems like sometimes they will take care of an emergency case and sometimes they will not. They have to wait out there.

Senator ANDREWS. But if they thought it was an emergency, then they would tell you to drive on to whatever hospital you would have to go to.

Mr. MASON. They do that sometimes, yes.

Senator ANDREWS. Has your tribe, Mr. Secretary, your business council, filed an official protest concerning this idiotic treatment?

Mr. MASON. We have. We come to every office now and then and the public health staff over there also tells them that, and we do have our service unit director. We tell them that all the time, every time that we have an emergency.

Senator ANDREWS. We have also been told by a Minot hospital that they have extreme difficulty in collecting any patient charges from IHS over about \$10,000. Of course, what they say is, Senator, do we throw them out when they are still critically ill if their treatment costs have reached \$10,000?

Mr. MASON. That is true. They will not pay it unless the patient is referred by a doctor and sometimes that will not get paid either.

Senator ANDREWS. You mean it has to be one of the Indian Health Service doctors that does the referring because, obviously, if you are in an emergency and you drive your wife or your child or your mother or your neighbor to the closest hospital—which I would assume would be Minot, would it not?

Mr. MASON. Well, on the eastern part would be Garrison and on the northern part would be Minot.

Senator ANDREWS. And the west would probably be Williston?

Mr. MASON. Watford City or Williston.

Senator ANDREWS. Well, when you drive them there, obviously they are seen by a doctor who happens to be on emergency duty in the hospital and the doctor says: "Yes, sir, indeed they are sick. We have got to put them in the hospital on an emergency basis," but the Indian Health Service insists they be referred by one of their doctors.

Mr. MASON. That is true.

Senator ANDREWS. Well, can you get an Indian Health Service doctor to come up to the hospital to which you took this emergency patient, to look at him and certify it that day?

Mr. MASON. Well, the answer to that would be that we would have to stay at the clinic.

Senator ANDREWS. Do they do appendectomies at the clinic? If you are having a heart attack do they have an intensive care facility for that?

Mr. MASON. No. No, they do not.

Senator ANDREWS. So, they say you have to stay at the clinic. That is almost no medical care at all.

Mr. MASON. That is true. I have two cases: one my father and one a man that was on the tribal business council with me here. He died last year.

Senator ANDREWS. What happened to him?

Mr. MASON. That guy, his name is Willart Little Hour. He had a heart attack. And the service unit—the doctor wanted to fly him over to that district, the Twin Buttes district. The service unit director would not authorize it and he just about had to beg her because he knew the situation—that he was a councilman—he was getting a little special treatment from the doctor. When they finally got to him they took him to Bismarck and when the doctor got down there it was too late.

Senator ANDREWS. And the delay was caused by the bureaucracy of the Federal Government.

Mr. MASON. That is true.

Senator ANDREWS. In your opinion, are there enough doctors to serve the tribal patients that need treatment in your area?

Mr. MASON. No.

Senator ANDREWS. Do you rely on private contract health care in your area?

Mr. MASON. We have Dr. Wilson in New Town who is the doctor for the nonmembers in New Town but also serves at the public health.

Senator ANDREWS. Are you satisfied with the treatment that tribal patients receive under this contract health care?

Mr. MASON. No, sir.

Senator ANDREWS. Why not?

Mr. MASON. A lot of our members who are old, and the unemployed, are looked down on, more so than those who maybe have a little pull with the tribal council or who have maybe a little more money than the rest.

Senator ANDREWS. Have any members of your tribe been refused medical treatment either by the Indian Health Service or by private contract care provided?

Mr. MASON. I cannot say that right off hand, Senator. I will not.

Senator ANDREWS. Carl, have you had the same kind of problems?

STATEMENT OF CAROL McKAY, FORMER TRIBAL CHAIRMAN, DEVILS LAKE SIOUX TRIBE

Mr. McKAY. At Fort Totten we have a different—

Senator ANDREWS. At Fort Totten you are much closer to a facility in Devils Lake.

Mr. McKAY. Right.

Senator ANDREWS. If one of your tribal members has a medical emergency, the family would necessarily take them to the hospital in Devils Lake I would imagine.

Mr. McKAY. Right. At Fort Totten we were experiencing the same type of problems in terms of emergencies. The main reason I guess for the control, Indian Health Service contends, and one of the reasons they want to screen the visitation, is because of the lack of dollars available to the Indian Health Service to cover all contract health care.

Senator ANDREWS. In other words, if you have an emergency appendectomy you must seek out the Indian Health Service doctor before you can go to the emergency room doctor at the Devils Lake hospital?

Mr. McKAY. That has been pretty much the case. However, we are fortunate there that the Devils Lake facility is just 13 miles north of our service unit.

Senator ANDREWS. Well, what do you do, run for the doctor or go to the hospital? Suppose you are in pain or you have a heart attack and all the symptoms of a drastic emergency. Do you have to go to seek out the doctor before you go to the hospital?

Mr. McKAY. The Indian Health Service has tried to restrict people from going directly to the hospital. However, there have been cases that I am aware of where there have been authorizations by phone.

One of the things that needs to be worked out is that there should be some type of admission privilege given to the Indian Health Service doctors at those service units or those hospitals outside of the reservation. One of the things that we are lacking is the lack of cooperation, I believe, from the hospitals outside of the reservation in terms of giving our Indian Health Service doctors certain hospital privileges for admission; that type of thing.

Although that is probably not a concern that can be addressed by this committee, it is up to the individual Indian reservation, I believe, and Indian Health Service to work out some type of a format to get better cooperation from these contract hospitals.

Senator ANDREWS. Have any members of your tribe been refused medical treatment by these contract care providers?

Mr. McKAY. I have been away from the reservation for about 2 years now, so I hesitate to answer that at this point.

Senator ANDREWS. At the time you were on the reservation, was that the case?

Mr. McKAY. No, there were different screening procedures at the hospital itself so that if there was no authorization from the Indian Health Service then they would tend not to service or provide medical care to some of our members.

Senator ANDREWS. In your opinion, are there enough doctors to serve the tribal patients that need treatment in the Fort Totten area?

Mr. McKAY. Definitely not. There just are not enough doctors and, you know, for a while there we did have some doctors on staff, I think, because of the end of the Vietnam war or something to that effect. We just do not have any doctors that are ready to come out there now.

Senator ANDREWS. How many doctors do you have there now, Carl?

Mr. McKAY. At the present time, we have doctors that are coming in from other service units and we have a physician's assistant.

Senator ANDREWS. So, there are no resident physicians on the Fort Totten Reservation.

Mr. McKAY. Right.

Senator ANDREWS. And the dispensary there is staffed by people who come in on an occasional basis?

Mr. McKAY. Well, they do have a small lab and dental facilities and those people are employed by the Indian Health Service.

Senator ANDREWS. But not doctors.

Mr. McKAY. Presently, they do not have a regular doctor available to them.

Senator ANDREWS. So you have a contract physician in Devils Lake?

Mr. McKAY. Well, they have a contract there for hospital care.

Senator ANDREWS. Has your tribe received the report of the task force on contract health care?

Mr. McKAY. I assume they have.

Senator ANDREWS. Has yours, Matthew?

Mr. MASON. Pardon?

Senator ANDREWS. Has your tribe received the report of the task force on contract health care?

Mr. MASON. Yes.

Senator ANDREWS. Have you had time to analyze that very lengthy report?

Mr. MASON. Not with the committee, no.

Senator ANDREWS. So you would have no response as yet to the recommendations of that task force.

Mr. MASON. No.

Senator ANDREWS. Mr. White Lightning, what is the situation at Standing Rock?

Mr. WHITE LIGHTNING. Al White Lightning, speaking for Pat McLaughlin, Standing Rock Sioux Tribe.

Senator ANDREWS. Al, what is the situation in the Standing Rock area? Is it essentially the same?

STATEMENT OF ALLEN WHITE LIGHTNING, REPRESENTING PAT McLAUGHLIN, CHAIRMAN, STANDING ROCK SIOUX TRIBE

Mr. WHITE LIGHTNING. To some degree, yes, but I am going to have to make a statement, Senator, regarding the service unit.

You know, since October, we have had a change in the service unit director. We have a woman who is also a member of the tribe who is very competent and understands the needs back home and she has been there for 8 months and she has been trying to turn things around. I believe she inherited the problems that we have and she has been very, very helpful to the tribal council and also to the staff. She has been meeting with the staff and council regularly so I think that in reference to our predecessors speaking, we have to be very—what, not disagreeing—but then we are trying to resolve the issues.

Senator ANDREWS. But on your reservation, Allen, if one of your tribal members becomes critically ill, how long does it take to get them to the hospital and to which hospital do you go?

Mr. WHITE LIGHTNING. Let me illustrate. Bullhead, which is 80 miles southwest on the South Dakota side, has an ambulance service and the ambulance is very slow getting there. From Fort Yates to Bullhead, it would take approximately 1½ hours to get to the patient's home and then bring them back to the Fort Yates hospital.

I was on the tribal council previously. One of the things that we recommended was that the Bullhead people be transported to the Mobridge Hospital but that did not happen.

Another thing that has been going on is that people are going directly to the Mobridge Hospital and requesting assistance without approval or authority from IHS. One of the things that we have been told by the IHS or the Mobridge Hospital in South Dakota is that we have outstanding debts there numbering maybe \$100,000 or so which, I understand, Indian Health Service has not paid yet. The reason that has been given is that, previously, the Indian Health Service service unit director did not approve the treatment for payment. In my discussions with him, the hospital administrator has indicated to me that he was not going to turn away a sick Indian man, lady, child; that he was going to provide them services and so we have a good working relationship with the Mobridge Hospital and I think we still—

Senator ANDREWS. And you still are \$100,000 in arrears because it has not been certified by the Indian Health Service.

Mr. WHITE LIGHTNING. Maybe the figure has gone down. This was 2 or 3 years ago. I believe the area director is sitting behind me. She can verify or disagree.

Senator ANDREWS. Richard, what is the situation up at Belcourt? Richard LaFromboise, chairman of the Turtle Mountain Band. You are much closer to hospitals. You have your choice of a couple.

STATEMENT OF RICHARD LaFROMBOISE, CHAIRMAN, TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS

Mr. LaFromboise. Well, Senator, first of all, on behalf of the other tribal chairmen, welcome back home.

Senator ANDREWS. Good to be here.

Mr. LaFromboise. It is kind of sad that we lost another old soldier who worked for us for many years.

Senator ANDREWS. It is indeed.

Mr. LaFromboise. I am just getting down to the nuts and bolts of Indian health on the Indian reservation. We are having a hard time. Without getting down to dog fights on the local level, as to whose responsibility is whose responsibility, I think it all stems from our bureaucratic maze that we have to continually fight or to address.

The continual layering of the Indian Health Service at the top end is becoming completely unresponsive to us at the field level. I think the basic problems that we have at home concerning service to our Indian people, and who gives permission to do what, all stems from up above.

As for our contract health care moneys, we at Turtle Mountain are directed continually that only in life-or-death cases may we direct our people to outside hospitals, and 9 times out of 10, the hospital that the individual is directed to must have a doctor of specialty in that area, and, if it does not, then the medical payment is questioned.

Now the problem that we have at Turtle Mountain, and I think at the other reservations, is the inadequate amount of funding for each one of those reservations.

At the present time, Turtle Mountain has not received an increase for an alcoholism program that has been in operation for 10 years. I hate saying it, but I think that the No. 1 problem on Indian reservations is alcoholism. We have 95 percent of our court cases involved with it, 70 percent of our accident cases in our hospitals are involved in it, but yet we have not really dealt with an issue that is very critical to us.

From September 1980 to September 1981 there were approximately 51,654 people seen by 5 doctors. That is a problem. We do not have enough personnel. We do not have enough moneys to spend to get adequate care for Indian people.

I represent 20,000-plus Turtle Mountain Chippewa Indians. Over half of the Indian population in the State of North Dakota. We are continually fighting to improve education.

I really appreciate the relevant discussion that the young Indian students from INMED gave to you as to the need for this program. I know that next year we are going to lose four of our six doctors that we have at the present time. Of course, we have four doctors that are Turtle Mountain Indians who are going to be graduating, and hopefully they will be coming home.

Senator ANDREWS. Now, you have six doctors at the present time at Belcourt who will still be there?

Mr. LAFROMBOISE. That is right, but I'll be losing one next week.

Senator ANDREWS. You will be losing one next week and three others in the next year.

Mr. LAFROMBOISE. Right.

Senator ANDREWS. Where are these doctors going? Are they retiring or are they transferring to other places, or what?

Mr. LAFROMBOISE. Well, from time to time they get a chance to come out and pay back their time and service for education so they spend their time in the field with Indian Health Service. Some of them are—like the doctor that is leaving next week are going back to the university for 2 more years of specialized training so that he can then go back into the field in a certain area.

From what I gather, being a doctor is a continual educational system and that they continually have to develop their skills.

Now without INMED, and without special programs such as this, I believe that we might as well forget about educating Indian doctors because they are going to be very few and far between.

Indian health today needs specialization. You saw the relevancy that was given here by the five students. Being Indian they have a special interest or a vested interest in the Indian reservation. Even though they do not sign a contract stating that they will return, they have a moral or an inner conviction that they will return and when they do testify before you, Senator, they testify with enthusiasm. They are not just another appendectomy or another type of illness. It is a real relevant reason to them. They are going to go back home. They are going to live there. They are going to become prospering members of that community and contribute to it. And that, Senator, is about as high a regard that I can give to the INMED program.

I think that the adequate funding again is a problem. We witnessed, as you recall earlier, the testimony in Washington, D.C., when you

asked for Indian Health Service to do their testifying. We had, of course, relevant people, Indian people that have an inside and adept look at Indian health but they were muffled. They were people that had worked with this INMED program.

We even had a director of Indian health who was in Washington, D.C., and was somewhat muffled by two or three administrators that were layered above him and in effect reading a management study of Indian health and how to cut it back. That is not a way in which to deal with direct service to Indians on Indian reservations. That is from the bottom.

Senator ANDREWS. Well, let me assure you, Mr. Chairman, there are different personalities on every reservation and every tribe just as there are in every county and every community and wherever you might be.

The purview of this committee and the reason we are having these hearings here and in Alaska and other areas is to find out what common thread of idiocy—and I think that is as good a word as any—runs through the delivery of this health care system to the tribes and I think we have found some common chords in this kind of testimony.

You can have the most outstanding individual in the world. As Allen said, you have got an Indian woman who is beginning to work, beginning to establish some rapport with the tribe and the tribe has confidence in her. But, if she has directives coming down from above, this is what we have to address, so that when you do get a dedicated and competent person in the field who will serve, then they will be given the freedom to serve. That is the purpose of these hearings and that is why what has been said here has been so helpful.

Mr. LAFROMBOISE. I have been instructed by the chairman and the council to bring this issue to this committee. The director of Indian Health Service in Washington, D.C., does not really make the decisions. It is people above him, and we are finding that it is necessary for tribes to begin recommending that the Director of Indian Health Service be elevated to an Assistant Secretary of Health position. Maybe then he would not have to be blaming people above him and maybe we can get some relevant direction.

Senator ANDREWS. That is an excellent suggestion.

Incidentally, let me point out that the committee will be most interested in receiving for the record tribal positions from the four of your tribes on the issues that are presented in this task force report on contract care.

Mr. MASON. Senator, yesterday, we had a council meeting and the Oglala Sioux passed a resolution that they abolish the BIA area office and work on a Government basis with Washington from the tribal business council. The way it was talked about around the table, as to what it did to the IHS area office, maybe the tribes will get more contract money for more medical services there. Along that line, I want to thank you for recognizing the treaties in your opening statements.

Senator ANDREWS. Well, that is the key justification for this whole committee hearing.

Mr. MASON. In our written testimony, we placed the 1851, the 1866, and the 1891 treaties with the three tribes. Along that line there is a problem with our funding being cut for our community health repre-

sentatives. They are a great help with the way our situation is on the reservation, where they have to go all the way around the Garrison Dam to see a patient. They are almost as qualified as a public health doctor to maybe give that patient aspirin and let him rest a little bit. We are going to lose quite a bit of communication there. The community health representative program was a lot of help and provides a lot of services to the people there.

Senator ANDREWS. That is going to be most helpful. Do any of you have any further comments?

Mr. LAFROMBOISE. I do, Senator.

Senator ANDREWS. Yes. Go ahead.

Mr. LAFROMBOISE. I would like to endorse the community health representative program. The community health representatives on our reservation brought down the cost per patient from approximately \$650 to \$479, or something pretty close to \$100 over a period of 5 to 6 years that it was in operation.

Senator ANDREWS. That was because the tribal members were encouraged to get medical care early.

Mr. LAFROMBOISE. Right. And it worked on a preventive basis.

I am not saying it is going to be a save-all for our program or Indian Health Service on our reservation, but when you deal with 51,654 patients in 1 year, with only 5 doctors, you have somewhat of an overload, and you cannot carry on medical services, as the young man stated earlier, out of a cardboard box. I think that what has to be looked at is a very relevant outline of needs of Indian people in this area.

We have been discussing amongst tribal chairmen how we, as tribal leaders, can give some input to Indian Health Service to develop our needs. We could regionalize. We could streamline like all these other agencies have tried to do, but we do not have the money to do that.

We can give the added input as to how the Turtle Mountain Tribe could best serve the Fort Berthold Tribe or how Fort Berthold could help Turtle Mountain in different areas. At the present time Turtle Mountain is probably one of the only Indian Health Service agencies or hospitals in the area that is doing surgeries. It is on an experimental basis where doctors are coming in here from Grand Forks and doing surgery at Fort Totten. Now that will cut down the cost and the cost to the taxpayer.

From our standpoint, I think it is worth reflecting on the treaties and that inherent right to Indian health, education, and welfare. We want to be able to show the American taxpayer that we can save money, too. We can show you how to save money without having a whole bunch of bureaucracy in between us and the Washington distribution office and I think that tribes at the present time are now in an era of being able to develop for their own future. But we can not develop for our own future if no one is listening and if they keep layering the Indian Health Service so that we cannot get a response to a very simple question.

Senator ANDREWS. Of course, that is the problem—so much Federal bureaucracy.

Mr. LAFROMBOISE. That is right.

Senator ANDREWS. I found that the Office of Management and Budget, when it comes to dealing with farm programs, does not know the difference between a steer and a heifer and I don't imagine they are much more expert in health care situations.

Mr. WHITE LIGHTNING. Well, Mr. Chairman, one of the things the Standing Rock Sioux Tribe feels very strongly about is the INMED program. We have two enrolled members of our tribe who are participants. We have had the opportunity to hear one of our enrolled members, Mr. Keoke, and the other person is Mr. Luger. I would like you to recognize him.

The other thing, Mr. Chairman, is we have not really heard too much noise about the reauthorization of Public Law 94-437. I believe we do support that by resolution. Those are in the documents we have.

Senator ANDREWS. That is right. We have those and they are a part of the record.

Mr. WHITE LIGHTNING. One last point I would like to make here is in reference to the INMED program. Again, we did pass resolutions, which we submitted to all the congressional people, and I would like to indicate here for the record and very briefly the latter portion of the resolution which says that the Standing Rock Sioux Tribal Council urges its congressional delegation to introduce legislation for reauthorization of Public Law 94-437, the Indian Health Care Improvement Act, with full funding for scholarships to be available to the INMED program and further supports that special congressional appropriation be made and added as a line item to the Indian Health Service budget for INMED; that INMED be included within the regular budget of Indian Health Service as part of their regular program implementation.

And this is—the next portion, Senator, is very important to us because we feel that this individual is doing the best that she can—is that we also include in our resolution that:

Be it further resolved that Dr. Lois Steele, director of the INMED program, be retained with the program; and that the Tribe opposes the Indian Health Service policy of transferring personnel who are successfully operating programs on the reservations or to the reservations; that the Standing Rock Sioux Tribal Council urges the INMED advisory board to retain Dr. Steele in that particular position;"

and these are, this is a tribal council resolution. I have been instructed to bring this to your attention also and we would appreciate your time with this.

Senator ANDREWS. Thank you so much. Finally, Carl, do you have anything to add?

Mr. MCKAY. Yes; I would just—

Senator ANDREWS. One of North Dakota's eminent about to be lawyers as well as a tribal leader.

Mr. MCKAY. I do not know about that, but thank you anyway.

I would just like to add to the fact that the CHR program—and you certainly recognize the value of that and knowing that, I do not feel I need to add to any of the comments that have been expressed thus far.

I would like to state, however, that there is need for continued financial support for the contracting process that has been authorized by Congress, the Public Law 93-638 program, and for continued

funding of the INMED program so that our young Indian people, young and old, can become trained in Indian Health Service areas or other areas. There is definitely no reason why Indian people cannot begin to administer and operate these programs from a reservation-based level. I think those are things that this committee will be looking at.

One other thing I think that is of great concern, at least for people back home, is that the present dollars that are available to Indian health be restricted to Indian members or people of Indian descent.

Senator ANDREWS. Do you find much problem with that? Are you finding a lot of the Indian health resources devoted to non-Indians?

Mr. MCKAY. For a while I know, a frequent complaint from some of the elderly people back home was that they would go into the Indian Health Service clinic and would be waiting to see a doctor or to get treatment, whatever, and it really bothered them to see non-Indians going in and getting services, while they would be waiting. So it has been a problem. We understand that the Indian Health Service is attempting to limit that now to Indian people.

In closing, Senator, I would like to extend the appreciation of myself and of Chairman White in your being on this particular committee. We have great confidence in you and we know, and I am sure most of the other chairmen and their representatives know, that these words will be taken with great care. Thank you.

Senator ANDREWS. Thank you very much. I have a response to that.

I remember that when I campaigned for the Senate seat there was a good deal of to do that I was leaving North Dakota's valuable seat on the House Appropriations Committee to move over to the Senate to satisfy my personal whims or whatever. That was the political talk that was going around. But in traveling around the State through the 5 or 6 months of that campaign, nobody once said boo to me in all the meetings I attended about the committee assignments except on the Fort Totten Reservation where your tribal leaders said, that "when you are elected, we do hope you will seek a seat on the Select Committee on Indian Affairs." So, I came back afterward and I said, "Well, this is the report as far as it goes." I was elected and I responded to my constituents by getting a seat on the Select Committee on Indian Affairs. Then, in addition to that, I got placed on the Appropriations and the Agricultural and the Budget Committee.

So, I was asked by people to be on this committee and I am intrigued with the possibilities we have because it is one of the areas that addresses, in microcosm, so much of what goes wrong with big-brother government when it simply flows dollars at a situation and does not really do it with good judgment and common sense. As the chairman from the Chippewa Turtle Mountain group pointed out so well we know how to arrange these programs so that they can work a whole of a lot better than they are.

And I recall some 18 years ago, when one of my closest friends in the Congress, Ben Riffe, representative of the eastern district of South Dakota when I represented the eastern district of North Dakota, and I did a study together and we found that the Bureau of Indian Affairs was spending some \$750 I think for every Indian man, woman, and child in this country just on their own overhead. Besides that were the

education funds and the medical care funds and the housing funds but just to run the bureaucracy, and this was 15 years ago. For a family of five, that is \$3,500-plus that is being spent to interfere with programs which would probably work a whole of a lot better if they would leave them alone. So, I was indoctrinated into this a long time ago when Ben and I were involved with that.

We felt we needed three things. No. 1, access to education; No. 2, health care and housing; and No. 3, job opportunities on or close to the reservation. That is the way we could address the needs of our Indian people and get the maximum benefits for the Federal input. I have not found anything in all the testimony I have picked up in the last 3 years, serving on this committee, that has changed my mind from that opinion that Ben and I reached way back then. But we do appreciate your coming. You have made a great record and it will be most helpful to the committee and what we intend to do with the Office of Management and Budget down the pass. Thank you.

[The prepared statements, with enclosures, follow. Testimony resumes on p. 116.]

PREPARED TESTIMONY SUBMITTED BY ALYCE SPOTTED BEAR,
CHAIRMAN, THREE AFFILIATED TRIBES, TRIBAL BUSINESS
COUNCIL, FORT BERTHOLD RESERVATION, NEW TOWN, N. DAK.

INTRODUCTION

Honorable Senator Mark Andrews, Chairman of the Senate Select Committee on Indian Affairs. The Three Affiliated Tribes, Tribal Business Council appreciates the opportunity to present and express the following testimony on vital Indian Health issues and concerns:

FORT BERTHOLD RESERVATION

The Fort Berthold Reservation is located in Northwest North Dakota. Located here are 3 tribes the ARIKARA, HIDATSA, MANDAN. The Reservation encompasses approximately 1,000,000 acres. The resident Indian population is 3,081 (BIA Labor Force report).

Fort Berthold, like many other Reservations has severe health problems such as diabetes, hypertension, alcoholism, and acute otitis media and upper respirator infections. Additionally, comprehensive and immediate medical health care service delivery to Tribal Members is difficult to maintain due to the physical barrier created by Garrison Reservoir which was built by the U.S. Army Corp of Engineers. The Reservoir has created five isolated communities not directly accessible to the IHS Health facilities. An excellent example of this barrier is the fact that the Twin Buttes Community is located 120 highway miles from the Minni-Tohe Clinic at New Town.

ISSUE I.

PROBLEM:

President Reagan's Fiscal Year 1984 Indian Health Service Budget Proposal recommends that appropriation for the Indian Health Care Improvement Act be reduced and that the burden of health care costs should be shifted to individual Indian patients.

CONCERNS:

Are primary concerns with the recommendations are:

- 0 It is a legal responsibility of the U.S. Government to provide adequate health care to the members of the Three Affiliated Tribes. The Treaty of Fort Laramie, Treaty of 1866, Agreement of 1891, the Snyder Act, the Transfer Act and most recently the Health Care Improvement Act, P.L. 94-437 clearly and unequivocally mandates this.

(Treaty of 1866

" . . . , in providing necessary and proper medicines, medical attendance, care for and support of the aged, sick, and infirm of their number"

Agreement of 1891

" . . . , providing medicine and medical attendance and the wishes of said Indian should be consulted")

- 0 As adopted P.L. 94-437 was intended to increase health service financial resources which would eliminate documented back log in health care and establish a foundation for comprehensively meeting the health needs of Indian people. Unfortunately, appropriations

have never reached the level of expenditures authorized to carry out this mandate.

- 0 As noted the President's proposal shifts the burden to Indian patients. These individuals lack the financial capability to pay for rising health care costs. The Three Affiliated Tribes' Economic and Quality of Life Survey completed in 1982 revealed that Indian households on the Fort Berthold Reservation have average per capita income of \$4,630 per annum and 1982 unemployment rate was 43%.

ISSUE II.

PROBLEM:

Prior to the construction of the Garrison Dam/Reservoir the Three Affiliated Tribes enjoyed the benefits of a centrally located hospital facility. Because of the inundation of the previous site, no such facility now exists - only a small outpatient clinic facility is provided by Indian Health Service.

CONCERN:

Our concerns in this issue are as follows:

- 0 The Fort Berthold Reservation should have a hospital facility to replace that which was lost
- 0 The present utilization of off-Reservation hospitals under the contract care system creates a number of negative aspects: transportation problems for patients, employment lost to off-Reservation towns,
- 0 The Three Affiliated Tribes has a hospital facility feasibility study completed which justifies the construction of a hospital that will alleviate many of our health concerns. (A copy of the feasibility study is available upon request).

ISSUE III.

PROBLEM:

The President's Fiscal Year 1984 Budget proposal does not contain appropriations for the Community Health Representative program.

CONCERN:

Our concerns in this issue are as follows:

- 0 If funding for the Community Health Representatives program is not appropriated, vital home health care services to many of the older and poorer Indian people will be lost.

Approximately (i.e. 25% of all Indian household on Fort Berthold Indian Reservation do not own a vehicle - Economic Quality of Life Survey 1982).

- 0 The lack of funding will eliminate the many services. For example in 1982 the TAT HRD CHR program provided 2,460 home visits to chronically ill and home bound patients, 912 transportations to families without vehicles. To emphasize the physical transportation barriers noted in the introduction section, 52,800 miles were logged to provide essential health care services.
- 0 Defunding the Community Health Representatives program on Fort Berthold will mean the loss of employment for 10 staff. An extensive amount of money and time has been expended on training these persons to their current level of health expertise.

ISSUE IV.

PROBLEM:

Each Fiscal year expenditures for Contract Health Care services exceeds the Fort Berthold Service Unit Allocation.

CONCERN:

Our concerns in this issue are as follows:

- 0 Patient referrals to off-Reservation Contract Health Care facilities are delayed until a life-threatening medical emergency develops for each individual. The delays occur because there are inadequate Contract Health Care allocations for Fort Berthold which leads to expenditure restrictions.
- 0 Medical complications that could be treated/prevented early are delayed. This delay leads to a greater cost for both Indian Health Service and the patients because the medical condition is usually more critical at this in the later stages.
- 0 The Contract Health Care system authorization and reimbursement procedures are very complicated. This leads to financial and "red tape" problems for both the provider and the patient.

ISSUE V.

PROBLEM:

Fort Berthold Service Unit has not been successful at securing and retaining its allocation of permanent physicians.

CONCERN:

Our concerns under this issue are as follows:

- 0 The physician to patient ratio is not sufficient to meet the medical needs of Fort Berthold residents thus creating greater expenditures for off-Reservation contract care.
- 0 There is a lack of patient/physician continuity in medical care the constant cycling of temporary physicians leads to incomplete care or inconvenience for patients - for example, new medical tests

are ordered for a patient each time he or she is seen by a new physician.

- 0 Lack of full physician staffing can lead to a patient overload, detrimental to the retention of physicians. This patient overload discourages physician recruitment and retention. It is also a barrier to quality medical care in that the physician is forced to spend less time with each patient.

RECOMMENDATIONS

1. The Indian Health Care Improvement Act needs continued reauthorization with sufficient appropriations to carry out the original objectives of the Act.
2. A specific appropriations for the Three Affiliated Tribes should be provided to replace the hospital that was inundated by the construction of the Garrison Dam.
3. The Community Health Representative Program should be returned to the proposed FY 1984 Budget and maximum funding restored.
4. Contract Health Care allocations for the Aberdeen Area, and the Fort Berthold Service Unit in particular, need to be raised to a "realistic" level.
5. Additional funding appropriations should be made to all tribes for the development and management of the Reservation based physician recruiting and training programs to insure that Tribes procure culturally sensitive physicians.


 ALYCE SPOTTED BEAR, TRIBAL CHAIRMAN
 THREE AFFILIATED TRIBES
 TRIBAL BUSINESS COUNCIL
 FORT BERTHOLD RESERVATION
 NEW TOWN, NORTH DAKOTA 58763

PROGRAM ADJUSTMENTS
FORT BERTHOLD SERVICE UNIT

- I. Positions Vacant: 6 Value: \$163,296
- II. Services Reduced:
 1. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
 2. Payments for eyeglasses are restricted to school age children one time only.
 3. Direct Ambulance Program has been terminated and ambulance services contracted out on a per trip basis.
 4. Twin Buttes, White Shield, and Mandaree Clinic services have been cut because of medical officer vacancies.
 5. Previously donated clinic space is now only available on a rental basis causing inconvenience and reductions at Parshall.
 6. The Minne-Tohe Health Center has been closed on occasion because of lack of staff.
 7. The overall health status, i.e., supervision of Physician Assistants, school health, field health, specialty clinics, etc., are failing because of the unavailability of permanent medical staff.
 8. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.
- III. New Service Demands Because of Other Third Party Reductions:
 1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
 2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
 3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
 4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

6/1/83

1. Two Full Time Permanent Physicians.

2. Dentist and Dental Assistant
3. X-ray Tech - Full Time
4. One full-time receptionist - for answering phone and meeting patients.
5. If Position Ceiling could be raised to 27 full time employees. (Minni-Tohe Health Center).
7. Need monies for Medical Equipment - Wheel Chairs, hospital bed for home use.

The above request will provide;

- a. Better medical care coverage - direct care
- b. Consistent care with same Doctors (get to know the patients, etc.)
- c. Dental will be able to utilize Field Clinic for - screening of dental care needed in Communities.
- d. Medical equipment - will be used for convalescent care.
- e. Dollar value should be around \$68,000. - \$80,000. (positions)
\$ 5,000. (medical equipment)

**Three Affiliated Tribes
Business Regulatory & Enterprise Assistance Department
Fort Berthold Indian Reservation
New Town, North Dakota 58763**

DRAFT

It is a legal responsibility of the US Government to provide adequate health care to the members of the Three Affiliated Tribes. The Treaty of Fort Laramie _____ The Snyder Act, the Transfer Act and most recently the Health Care Improvement Act, P.L. 94-437 clearly mandates this.

Section 2 (a). Federal Health Services to maintain and improve the health of Indians are consonant with and required by the Federal Government's historical and unique legal relationship with and resulting responsibility to the American Indian people.

Most importantly, it is the general conviction of our tribal members that health services are to be provided in exchange for the loss of land taken years ago.

According to BIA 1981 estimates there are approximately 2505 enrolled members residing on the Fort Berthold Indian Reservation. The distribution of the population is estimated to be: New Town - 231; Mandaree - 795; Twin Buttes - 363; White Shield - 641; Parshall - 547. The rest of the population is living in outlying areas of the reservation. The man-made Lake Sakakawea has divided the reservation and long distances make travel difficult and often impossible for Indians seeking

Telephone (701) 627-3623

services at the Mini-Tohe clinic in New Town. The CHR Program often provides the emergency transportation to tribal members, particularly the elderly and chronically ill. The CHR Program is an essential component of health delivery to meeting the critical health needs to the members of the Three Affiliated Tribes.

- I. Legal Responsibility
- II. Health Care Improvement Act - need for construction/renovation.
- III. Importance of CHR Program - rural area - culturally sensitive staff. Impossibility of 3rd party resources - low in unemployment low economic status 2000/year.

Third party resources paid for by the Indian individuals are in fact subsidizing the Indian Health Service contract care budget. At Fort Berthold where most hospitalizations are done on a contract care basis, plus other special contract care services provided, the underwriting by these individuals becomes more apparent.

Contracting - need administrative monies to successfully deliver coordinated services.

'Indian Health Care Based in the U.S. Constitution,' Rhoades

BY NANCY WEST

Responding to the President's FY 1984 budget proposals for the Indian Health Service, Dr. Everett R. Rhoades, director of the Indian Health Service, stated in a memo that, "Time is not available to provide an opportunity for a discussion of the proposal or its merits either within the Department, the Congress, or with the Indian community.

"Because of the magnitude of the issue and to permit clearer and fuller development of the issue, IHS believes that any significant program changes should take place as part of the legislative, rather than the appropriations process. I therefore recommend that the Department seek approval to use Fiscal Year 1983 to resolve this issue," Rhoades stated.

A Constitutional Right

He said that the various special programs established by the Congress to provide health services to the Indian people are based on the constitutional supremacy of the Congress to regulate commerce with the Indian tribes and are a direct, historical outgrowth of treaties and the resulting Federal trust relationship.

"Though technically not an entitlement program, the IHS program is generally viewed by the Indian community as an obligation of the Federal Government, assumed in return for the cession of Indian land. In current terminology, IHS is viewed as a health maintenance organization for Indian people, prepaid by the Indians with their land," Rhoades noted.

He further stated that the current Office of Management and Budget proposal to require an individual Indian, whether economically secure or destitute, to pay for a service already considered to have been paid for—especially a service viewed as stemming from the trust relationship—would be a fundamental change in the nature of the IHS program and in the relationship between the Federal Government and the Indian tribes.

therefore, can be expected, Rhoades said. "Such a significant change in the IHS program will be widely viewed as an abrogation of treaty, legal, and moral obligations to the Indian people assumed by the United States at its insistence."

As a matter of departmental policy, IHS services are "residual" to other health care delivery systems and health care payment mechanisms, and accordingly, individual entitlement for such programs as Medicare, VA, and private insurance are used first.

Insurance Difficulties

"In the instance of private insurance, it has been difficult if not impossible to obtain payments from private third party insurers because of the fact that presently Indians are not held liable for the medical care provided to them by the Indian Health Service and therefore the insurance companies

do not pay, citing as a reason the fact that they exclude payment of bills for beneficiaries who are not held financially responsible for the services rendered," he wrote.

Rhoades said "We propose as a part of the recommended option that we will undertake a cost benefit analysis to be certain that the approach that we finally settle on is cost effective.

"With few exceptions, the Indian populations served by IHS have among the highest unemployment rates in the country. Their economic deprivation and high unemployment mitigate against the probability of substantial collections from individuals, and the low incidence of employer-supplied health plans also calls into question the probability of substantial collections from third parties. In short, the viability of the FY '84 budget assumption is unsupported," Rhoades contended.

Budget to Cut Services for Health Care

Health care, currently provided free of charge to all Indians who request service and are members of federally recognized tribes, will undergo fundamental changes if the proposals in the President's FY '84 budget for Indian Health Service, are enacted.

The Office of Management and Budget's proposal would bill Indians and third parties for the cost of care now provided by the Indian Health Service.

Hearings on the FY '84 budget for IHS, which has been submitted to Congress, were scheduled by the House Appropriations Subcommittee on Interior, and the Senate Appropriations Subcommittee on Interior in April 1983, and are anticipated to continue until June.

According to a letter from David Stockman, director of OMB, "Indian Health Service funding is to be supplemented with charges to individuals and third-party reimbursements (e.g., Medicaid, Medicare, Federal employee, liability, and other private health insurance)."

The Health and Human Services "will initiate administrative action and develop legislation, if needed, to continue Federal delivery of health services but, at the same time, achieve the policy of minimizing Federal funds," Stockman wrote in the Feb. 23 letter to Thomas B. Donnelly, acting Secretary of Health and Human Services.

"The Indian Health Service would operate in the manner of a county hospital — with public funds being the source of health care financing for those without resources," the letter states.

Furthermore, Stockman notes, "Given the agreement to implement the policy by Oct. 1, 1984, HHS needs to expedite its examination of issues involved. Discussions should be initiated first with the BIA and then with the State of Alaska on obtaining State reimbursements for health services currently being provided in lieu of State activities.

"An implementation plan for achieving these objectives should be submitted by May 16, 1983 with final plans being submitted by July 1, 1983."

WASSAJA

MARCH/APRIL, 1983

THREE AFFILIATED TRIBES • FORT BERTHOLD RESERVATION

Mandan, Hidatsa and Arikara Tribes

TRIBAL COURT

P.O. Box 501 • Mandaree, North Dakota 58757 • (701)759-3328/3329

May 31, 1983

Senator Mark Andrews
Chairman, Field Hearings Committee
on Indian Health Care Improvement Act
Washington, D.C.

Re: Services received

Honorable Mark Andrews:

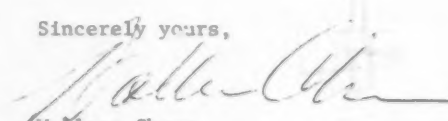
Due to the recent Federal cutbacks on many of our Contracts and Grants has caused numerous problems. One stand-out being, the limited availability of transportation funds, provided by the local Indian Health Service clinic to transport individuals to and from state institutions for alcoholism treatment.

Without an increase in this area, many of our Indian people will not be able to receive/obtain treatment mainly, because they do not have the personal funds necessary to travel the long distances to obtain this type of badly needed help.

We greatly appreciate your time and assistance.

Thank you.

Sincerely yours,


Wallace Chase
Tribal Court Administrator

WC/lo

cc: file

Art Bertold Rasmussen
New Town, N.Dak.
May 30, 1983

Hon. Senator Mark Andrews
451 Russell Bldg.
Washington, A.C. 20510
Honorable Senator;

I am taking this opportunity to let you know that we have inadequate facilities and our services (health) do not meet the needs of our Indian people.

Many of us do not seek medical attention due to the distance from the clinic. The clinic in New Town is especially a long way away from Twin Butte where I am from. And from personal experience, it is always a hassle to get them to authorize payments or visit outside doctors.

I do have Medicare and a Group Insurance but it does not cover every thing and they will refuse to cover what ever is left, which is not even any more than five hundred (\$500) and I am on a limited income which is a social security and small amount of lease money.

I am 74 years until July 10 and I will be 75 then and I speak from experience. We were faithfully promised a hospital when they were negotiations taking place over the Garrison Dam. When the government official told us. We couldn't have a hospital but we'd get health cards to be used any where within the United States, as usual, this promise was broken.

Many of us have heart trouble, Cancer Diabetes and a very high infant mortality rate. Our reservation also has a high rate of alcoholism.

The Community Health Representatives are very necessary for the sick and the elderly. Please consider keeping this program going.

The health personnel can do very little to improve this situation unless there is money and a decent budget to work with.

Please do what you can to improve the health situation on our Fort Berthold Indian Reservation.

Closing with kindest wishes

Sincerely

Catherine Fredericks

TO: Matthew Brown & under Mark Brown
 FROM: W. & Mrs. George Rice
 DATE: May 30, 1983

RE: On professional health service in recreation

W. George Rice went to I.H.S. Rec in New Town to have a tooth pulled and set there for about one time. Then they called me, so I went to the place.

They took 2 X-rays, but still they pulled the wrong one.

I returned there about one month ago to have the right one pulled so I got one good tooth.

→ I'm for better health service on the foot household recreation, other recreation, etc.

When our daughter was a baby she was very ill & we took her to I.H.S. and the nurse tended my wife at a Thermometer & told her to take her temperature. My wife was upset so we took her to Garrison Hospital and they put her right to bed. (That was in the 1950s)

Another time our son had an infection in his eye & the doctor gave him a shot

for an evening which made her
 sick with chills & fever. She went
 to another doctor and was ad-
 mitted to a hospital for 4 days.

against
 Mrs. Harry Rice
 & Constance Rice.



Pat McLaughlin
Chairman

HOME (605) 823-4876
Wakpala, SD 57658

TRIBAL OFFICE - (701) 854-7231
Fort Yates, ND 58538

TO: THE HONORABLE MARK ANDREWS
CHAIRMAN, SENATE SELECT
COMMITTEE ON INDIAN AFFAIRS
U. S. SENATE
CONGRESS OF THE UNITED STATES
WASHINGTON, D. C. 20540

FROM: PAT MCLAUGHLIN, CHAIRMAN
STANDING ROCK SIOUX TRIBE

SUBJECT: OVERSIGHT HEARINGS FOR THE RE-AUTHORIZATION OF THE
P. L. 94-437, "INDIAN HEALTH CARE IMPROVEMENT ACT"

MR. CHAIRMAN, I DID INTEND TO PERSONALLY TESTIFY AT THE PRESENT FIELD HEARINGS WHICH YOU ARE HOLDING ON THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT, P.L. 94-437; HOWEVER, I DO HAVE A REGULAR TRIBAL COUNCIL MEETING TO DAY AND IT IS CONFLICTING WITH THE HEARINGS; THEREFORE, I HAVE DECIDED TO SEND A MEMBER OF MY STAFF TO REPRESENT ME AND PROVIDE TESTIMONY FOR YOU. THIS LETTER WILL INTRODUCE MR. ALLEN WHITE LIGHTNING, MY SOCIAL DEVELOPMENT SPECIALIST WHO IS PRESENTLY WORKING IN THE AREAS THAT ADDRESS OUR CONCERNS.

I WOULD APPRECIATE IF YOU WOULD GIVE HIM THE SAME RESPECT AS WOULD BE ACCORDED TO ME. THANK YOU.

SINCERELY

PAT MCLAUGHLIN, CHAIRMAN
STANDING ROCK SIOUX TRIBE



Pat McLaughlin
Chairman

HOME - (605) 623-4876
Wakpala, SD 57658

TRIBAL OFFICE - (701) 854-7231
Fort Yates, ND 58538

JUNE SECOND, 1993

THE HONORABLE MARK ANDREWS
CHAIRMAN
SENATE SELECT COMMITTEE ON
INDIAN AFFAIRS
U. S. SENATE
WASHINGTON, D. C. 20510

TESTIMONY BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS OVERSIGHT
HEARINGS ON THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT,
P. L. 94-437.

MR. CHAIRMAN:

MY NAME IS AL WHITE LIGHTNING, AN ENROLLED MEMBER OF THE STANDING ROCK SIOUX TRIBE AND I AM REPRESENTING MR. PAT MCLAUGHLIN, CHAIRMAN OF THE STANDING ROCK SIOUX TRIBE WHO IS UNABLE TO BE PRESENT DUE TO CONFLICTING SCHEDULING AS HE IS CONDUCTING THE REGULAR TRIBAL COUNCIL MEETING SCHEDULED FOR TODAY.

THE STANDING ROCK SIOUX TRIBE IS VERY CONCERNED ABOUT THE NUMEROUS HEALTH PROBLEMS AND ISSUES WHICH IS A MATTER OF GREAT IMPORTANCE TO US. WE WILL NOT WASTE TIME AND BELABOR THE INDIAN HEALTH SERVICE FROM THE TRIBAL STAND-POINT. WE WILL, HOWEVER, CALL UPON YOUR COMMITTEE TO CONSIDER OUR CONCERNS AND ATTEMPT TO RESOLVE THROUGH THE LEGISLATIVE PROCESS THE QUESTIONS WHICH ARE NECESSARY.

IN ORDER FOR THE INDIAN HEALTH SERVICE TO PROVIDE HEALTH SERVICES AND CARE OF HIGH QUALITY, THE DIRECTOR OF INDIAN HEALTH MUST BE ABLE TO MAKE THE DECISIONS. WE UNDERSTAND THAT IS NOT THE CASE. THEREFORE, OUR FIRST CONCERN WHICH WE ASK YOUR COMMITTEE TO PURSUE IS THE ELEVATION OF THE POSITION OF THE DIRECTOR OF INDIAN HEALTH SERVICE TO THE LEVEL OF AN ASSISTANT SECRETARY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

"...under the direction of the Fort Laramie Treaty of April 29, 1868..."

IN CIA TESTIMONY
PAGE 2.

NATURALLY, WE WHOLEHEARTEDLY SUPPORT THE RE-AUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT, P.L. 91-447 BY TRIBAL COUNCIL RESOLUTION NO. 62-83 WHICH IS ATTACHED.

MR. CHAIRMAN, WE UNDERSTAND THAT A STUDY HAS BEEN CONDUCTED BY THE INDIAN HEALTH SERVICE ADDRESSING THE COMMUNITY HEALTH REPRESENTATIVE PROGRAM. THE STANDING ROCK SIOUX TRIBE HAVE IN THE PAST AND TODAY RECEIVED EXCELLENT SERVICES FROM THE PEOPLE WHO ARE WORKING FOR THIS PROGRAM. WE RECOMMEND THE CONTINUATION OF THIS PROGRAM!

WE HAVE BEEN APPRISED THAT THE INDIAN HEALTH SERVICE WILL NOT BE ABLE TO MEET THE BUDGET DEMANDS FOR THIS FISCAL YEAR AND THEY WOULD HAVE A SHORT-FALL. THIS AS YOU ARE WELL AWARE AFFECTS THE INDIAN PEOPLE TREMENDOUSLY AS THEN, THE SERVICE UNITS RECEIVE DIRECTIVES TO "ONLY" SERVE PEOPLE UNDER CONTRACT HEALTH CARE WHO ARE ON "PRIORITY ONE" WHICH I UNDERSTAND MEANS PEOPLE WHO ARE ALMOST DEAD! OUR PEOPLE NEED NOT BE SUBJECTED TO THIS, NO MATTER WHO WE ARE, WE ARE STILL PEOPLE, IN FACT, WE ALL HAVE THE SAME COLOR OF BLOOD RUNNING THROUGH US. WE SUPPORT ADEQUATE FUNDING FOR SERVICES WHICH OUR PEOPLE NEED. THESE FUNDS WHEN APPROPRIATED SHOULD BE ADDRESSING THE HEALTH CARE OF OUR PEOPLE, NOT HOW MUCH COULD BE SAVED AND CUT AT THE EXPENSE OF US!

THE STANDING ROCK SIOUX TRIBE HAVE CONTACTED YOUR OFFICE AND COMMITTEE FOR SUPPORT TO HAVE PERMANENTLY STATIONED PHYSICIANS AT FORT YATES AND McLAUGHLIN, SOUTH DAKOTA. WE QUESTION THE TERM "PERMANENT", AS WE HAVE BEEN TOLD BY THE I.H.S. THAT WE WOULD BE RECEIVING 'PERMANENT' DOCTORS BUT THEY WOULD BE HERE FOR MAYBE THREE OR FOUR MONTHS THEN THEY LEAVE. WE'RE RIGHT BACK TO WHERE WE STARTED—ASKING YOUR OFFICE FOR HELP!

WE HAVE CONTRACTED UNDER P.L. 93-638 FOR CERTAIN PROGRAMS FROM THE I.H.S.; BUT LIKE BUREAU OF INDIAN AFFAIRS, WE HAVE CONSISTENT PROBLEMS WITH OUT INDIRECT COST. WE REQUEST THAT BOTH AGENCIES THROUGH THIS COMMITTEE WORK OUT A SOLUTION, IF POSSIBLE, AMIABLE TO TRIBES. WE STRONGLY URGE THIS.

OUR PEOPLE, LIKE EVERYWHERE ELSE, HAVE A SERIOUS PROBLEM WITH ALCOHOLISM OR CHEMICAL DEPENDENCY; AND IT WOULD SEEM THAT INDIAN HEALTH SERVICE OR THE CONGRESS WOULD LOOK FAVORABLY AT ADDRESSING THESE PROBLEMS WITH APPROPRIATE FINANCIAL ASSISTANCE TO TRIBES. WE ARE CONSTANTLY, YEAR AFTER YEAR, BEEN UNDER-FUNDED.

HCIA TESTIMONY
PAGE 3

WE HAVE REVIEWED THE IMPACT OF COMPETITIVE BIDDING ON THE QUALITY OF AND ACCESS TO HEALTH CARE AROUND THE STANDING ROCK RESERVATION; AND WE HAVE TO ACCEPT THE HIGH COST OF HEALTH CARE AS THERE REALLY ISN'T MUCH TO CHOOSE FROM, IF WE VALUE THE PATIENT'S LIFE IN TRANSPORTING THEM.

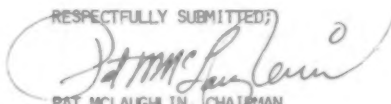
ONE OF THE MAJOR CONCERNS WE HAVE IS TRANSPORTING OUR PATIENTS IN FROM THE DISTRICTS AND WE HAVE CONTRACTED WITH THE INDIAN HEALTH SERVICE FOR AMBULANCE SERVICES WHICH WE FIND INADEQUATE. THE DIFFICULTIES IN GETTING INTO THE RURAL DISTRICTS AND THE DISTANCES BETWEEN THEM WILL NOT ALLOW OUR PERSONNEL IN THE PROGRAM MUCH REST. OUR FUNDING FOR PERSONNEL IS NIL AND THE SERVICES REQUESTED OF THEM ARE TREMENDOUS. WE ARE STRONGLY ASKING YOUR COMMITTEE ADDRESS THIS ISSUE.

AS YOU ARE WELL AWARE, MR. CHAIRMAN, OF THE UNMET HOUSING NEEDS OF OUR PEOPLE IS STRONGLY AFFECTED BY THE SUITABLE WATER AND SANITATION FACILITIES WHICH GO HAND-IN-HAND. RECENTLY WE ARE EXPERIENCING THE LACK OF FUNDING TO MEET THIS NEED. WHAT THE INDIAN HEALTH SERVICES WILL BE IN THE FUTURE IN THE AREA OF WATER AND SEWER IS SOME THING WHICH I DREAD SEEING.

MR. CHAIRMAN, I REALIZE THIS TESTIMONY IS LIKE A "WISH LIST" AND THAT YOU HAVE HEARD IT ALL, BUT HEAR IT COMING FROM US. THANK YOU FOR THE TIME AND THERE WILL BE ADDITIONAL SUPPORT MATERIAL SUBMITTED LATER FOR THE RECORD.

IF THERE ARE ANY QUESTIONS, I WOULD CERTAIN BE HAPPY TO RESPOND TO THEM.

RESPECTFULLY SUBMITTED;


PAT MCLAUGHLIN, CHAIRMAN
STANDING ROCK SIOUX TRIBE

RESOLUTION

NO: 62-83

WHEREAS, the Standing Rock Sioux Tribe is an unincorporated Tribe of Indians, having accepted the Indian Reorganization Act of June 18, 1934 with the exception of Article 16, and the recognized governing body of the Tribe is known as the Standing Rock Sioux Tribal Council, and

WHEREAS, the Standing Rock Sioux Tribal Council, pursuant to the Amended Constitution of the Standing Rock Sioux Tribe, Article IV, Section 1(a) and 1(c) is empowered to negotiate with Federal, State and local agencies in matters which affect the Standing Rock Sioux Tribe and is empowered to promote and protect the health, education and general welfare of the members of the Tribe, and

WHEREAS, the Standing Rock Sioux Tribal Council recognizes the critical shortage of professional medical personnel - doctors, nurses, etc - and further recognizes the positive impact Indians Into Medicine Program (IN-MED) is making in preparing well-qualified health professionals who will provide health care acceptable to the Indian people, and

WHEREAS, the Indians Into Medicine Program (IN-MED) is presently operating through the auspices of, Title I of the P.L. 94-437, "the Indian Health Care Improvement Act's" legislative purview and administrative authority of the Indian Health Service, and

WHEREAS, the IN-MED Program has proven to be successful and cost beneficial in meeting its goals and the needs of the Indian People, and

NOW THEREFORE BE IT RESOLVED that the Standing Rock Sioux Tribal Council urges its Congressional delegation to introduce legislation for re-authorization of PL 94-437, The Indian Health Care Improvement Act with full funding for scholarships to be available to the IN-MED Program and further supports that special Congressional appropriation be made and added as a line item to the Indian Health Service budget for IN-MED; and that the IN-MED be included within the regular budget of I.H.S. as part of their regular program implementation and

BE IT FURTHER RESOLVED that Dr. Lois Steele, Director of the IN-MED Program be retained with the Program; and that the Tribe opposes the I.H.S. policy of transferring personnel who are successfully operating a program(s) on the Reservations or to the Reservations.

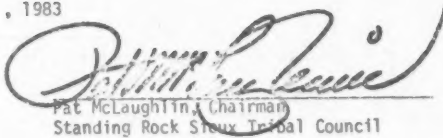
BE IT FURTHER RESOLVED that the Standing Rock Sioux Tribal Council urges the IN-MED Advisory Board to accept this resolution as a resolution of support for continued operation of the In-Med Program and the retention of Dr. Lois Steele with the Program.

BE IT FURTHER RESOLVED that the Chairman and the Secretary of the Tribal Council be authorized and instructed to sign this resolution for and on behalf of the Standing Rock Sioux Tribe.

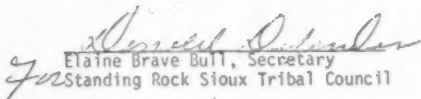
CERTIFICATION

We the undersigned Chairman and the Secretary of the Tribal Council of the Standing Rock Sioux Tribe, hereby certify that the Tribal Council is composed of 15 members, of whom 15, constituting a quorum, were present at the meeting thereof, duly and regularly called, noticed, convened and held on the 3rd day of February, 1983 that the foregoing resolution was duly adopted by the affirmative vote of 12 members, with 0 opposing, and with 3 not voting. The Chairman's vote is not required except in case of a tie.

RESOLUTION

NO: 62-83Dated this 3rd day of February, 1983
Pat McLaughlin, Chairman
Standing Rock Sioux Tribal Council

ATTEST:


Elaine Brave Bull, Secretary
for Standing Rock Sioux Tribal Council

(OFFICIAL SEAL)



COMPREHENSIVE CHEMICAL PREVENTION PROGRAM

Standing Rock Sioux Tribe
P.O. Box 517
Ft. Yates, N.D. 58538
Phone No.: 701 854-7219

CLOSING REPORT - JULY 1981 - DECEMBER 1982

Contract No. 241-80-0294, 241-81-0195,
241-82-0084 & 241-83-0020

North Dakota 1605 - FY 1981 - FY 1982
FY 1982 thru 12-31-1982

What is the Chemical Prevention Program? We are a program working toward the prevention and intervention of chemical use and abuse on this reservation. We operate under a IHS contract and two state grants.

Our program staff feel very good about the number of services and contacts made this past year. It shows that many more people have been given some information and help in the area of chemical dependency.

Our program has the following goals:

- 1) To provide education and prevention services to all communities, schools and youth.
- 2) To provide counseling on an out-patient basis for the chemical dependent and his family.
- 3) To provide referral and transportation services for those seeking in-patient treatment.
- 4) To provide aftercare services and follow-up for those returning from treatment.

PROGRAM PHILOSOPHY:

Alcoholism is an illness that affects the family, social, spiritual, physical and emotional being of the chemically dependent.

CONTRACT INFORMATION:

- I. Alcoholism - IHS Contract No. 241-83-0020. Staff: (1) Director, (1) Secretary, (1) Data Analyst, (2) Counselors.
Budget Amount \$90,160.00

God grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference.

**Chemical Prevention Program
Close-out report:**

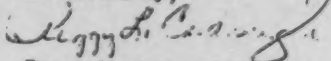
- II. ND State Alcohol and Drug Education Fund, (House Bill 1605).
Staff: (2) Prevention/Education Instructors. This grant is from the state of North Dakota for in-school youth education on alcohol and drug abuse for North Dakota residents only. The funding ends June 30, 1983. Budget amount \$40,303.00.
- III. ND D.U.I. Grant - Staff: 1 D.U.I. Instructor/Community Educator. Provides D.U.I. classes on all D.W.I. court cases and assists in education goals for communities. Budget Amount \$5,000.00.

TOTAL STAFFING: (8)

The program accomplishments can be noted by the statistics enclosed. Statistics from the opening of the program in 1973 through the fall of 1981 have been provided to show comparisons in services and contacts provided in an eight year period to a one year period. We, the staff, feel that we have made an accomplishment in making the subject of chemical dependency a less closed door subject and one of less embarrassment to approach. We also have seen that people of the districts are becoming more aware of the symptoms and problems related to alcohol and drug abuse and are learning how and where to seek help, even that the tribe has the service available to all its members. The subject of chemical dependency is also being looked at by the tribal government, law enforcement, courts, clergy, health and social services more seriously. As it is also in the communities, schools and by youth and parents,

Our participation for counseling and referral for in-patient and out-patient treatment has shown a younger age seeking help. It is our hope that in this one year, we have reached some of the youth and given education that will one day help in their decision of whether to use alcohol or drugs. We also hope that community members and parents are more aware of chemical dependency and how to get help for their family and friends. All of these are steps to a more successful future for everyone. As stated at one time: True success and accomplishments are not measurable in the field of alcohol and drugs. We can only hope that the added contacts and increased number of residents serviced, have been given information on chemical dependency that will be of help in their problem or addiction of chemicals. We feel that we have had a very successful (2) years and hope the new year will be just as rewarding to us and our communities.

Submitted by,



Peggy L. Cavanaugh
Program Director

COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

July 1981 - DECEMBER 1982

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COMPREHENSIVE CHEMICAL PREVENTION PROGRAM

Total Services Per Component
July 1981 - September 1982

In-Patients Services Oct. 81 - Dec. 81.	<u>56 Patients</u>
In-Patient Direct Hours	<u>1,654 Hours</u>
Out-Patient Clients Seen	<u>213 Clients</u>
Out-Patient Direct Hours	<u>1,099 Hours</u>
Travel Hours Indirect	<u>721 Hours</u>
Travel Hours Direct	<u>222 Hours</u>
Education/Prevention Sessions	<u>462 Sessions</u>
Attendance (Sessions and Contacts)	<u>1,780 Persons</u>
Off-reservation In-Patient Referrals	<u>121 Referrals</u>
Total Man Hours	<u>34,104.4 Hours</u>

GLOSSARY

In-Patient Treatment: To stay inhouse for treatment with other chemically dependent receiving education, individual and group counseling, to look at how chemicals have and do effect your life and those around you and to make a plan as to arresting the illness.

Direct Hours: Hours spent specifically in that area and component.

Out-Patient: Same treatment as In-Patient except on a scheduled time at an office. Do not board at the facility.

Travel Indirect: Travel done alone.

Travel Direct: Travel done with the client.

Education: Information given to those in attendance on all and any aspect of chemical dependency.

Prevention: To prevent the use of alcohol and drugs through things to do constructive and fullfilling.

Chemical Dependency: Dependency on any form of mind altering drugs this includes alcohol. Examples: "Grass, Speed, Hard Drugs, Prescription Drugs, etc..."

COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

In-Patient Component
Comparison of Services Per District

DISTRICT (1973-1981)	FEMALE	MALE	TIMES ADMITTED
Bullhead, South Dakota	22	50	361
Kenel, South Dakota	8	21	189
Little Eagle, South Dakota	26	61	319
McLaughlin, South Dakota	11	16	103
Wakpala, South Dakota	13	42	77
Cannon Ball, North Dakota	32	100	486
Fort Yates, North Dakota	88	145	1,525
Porcupine, North Dakota	0	5	17
TOTAL	200	440	3,087

AGE VARIATION (1973-1981)

AGE GROUP	FEMALE	MALE	AGE GROUP	FEMALE	MALE
18 & Under	17	56	40-49	33	73
19-29	66	126	50-59	16	60
30-39	63	94	60 & Over	5	31
			TOTAL	200	440

OUT-PATIENT COMPONENT
January 1982 - September 1982

AGE VARIATION

AGE GROUP	FEMALE	MALE	AGE GROUP	FEMALE	MALE
18 & Under	1	4	40-49	10	24
19-29	22	54	50-59	5	20
30-39	15	45	60 & Over	1	8
			TOTAL	45	126

COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

Contract Services Per Quarter
Annual Report - July 1981 to December 1982

<u>IN-PATIENT</u>	<u>MALE</u>	<u>FEMALE</u>	<u>TOTAL</u>	<u>DIRECT HOURS</u>
July 1981	13	2	15	117
August 1981	--	--	--	---
September 1981	--	--	--	---
October 1981	2	1	3	115
November 1981	19	3	22	738
December 1981	15	2	17	684
TOTAL	49	7	56	1,654

OUT-PATIENT DIRECT HOURS

July 1981	8.5	April 1982	75.0
August 1981	12.4	May 1982	11.0
September 1981	20.0	June 1982	142.0
October 1981	35.0	July 1982	79.0
November 1981	16.0	August 1982	142.0
December 1981	35.9	September 1982	101.0
January 1982	7.0	October 1982	56.0
February 1982	27.5	November 1982	58.0
March 1982	95.0	December 1982	79.0
		TOTAL DIRECT HOURS	1,099.0

COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

Out-Patient Clients
Serviced Per District
June 1981 - December 1982

Bullhead, South Dakota	23
Kenel, South Dakota	6
Little Eagle, South Dakota	17
McLaughlin, South Dakota	15
Wakpala, South Dakota	9
Cannon Ball, North Dakota *(1)	29
Fort Yates, North Dakota *(1)	103
Porcupine, North Dakota *(1)	4
Off-Reservation *(1)	7
*(deceased)	
TOTAL	213

COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

Total Man Hours Per Quarter
July 1981 to December 1982

July 1981	1,258.0
August 1981	1,428.0
September 1981	2,466.0
October 1981	1,020.0
November 1981	1,758.5
December 1981	3,309.0
January 1982	1,575.0
February 1982	1,290.0
March 1981	2,518.0
April 1982	1,920.0
May 1982	2,100.0
June 1982	2,335.0
July 1982	2,544.0
August 1982	2,429.0
September 1982	2,161.9
October 1982	1,155.0
November 1982	1,255.0
December 1982	1,582.0
GRAND TOTAL	<u>34,104.4</u>

COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

Travel Hours

	<u>TRAVEL INDIRECT</u>	<u>TRAVEL DIRECT</u>
July 1981	28	0
August 1981	45	13.5
September 1981	23	1
October 1981	7.5	0
November 1981	8	0
December 1981	6	6
January 1982	14	0
February 1982	24	13
March 1982	27.5	14.5
April 1982	114	31
May 1982	22	8
June 1982	74	23
July 1982	93	9
August 1982	117	25
September 1982	44	12
October 1982	30	20
November 1982	14	18
December 1982	31	29
GRAND TOTAL	721	222

COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

Education - Prevention Component
(July 1981 - December 1982)

	<u>Number of Sessions</u>	<u>Number in Attendance</u>
July 1981	7	68
August 1981	15	273
September 1981	14	457
October 1981	10	127
November 1981	12	188
December 1981	15	124
January 1982	12	674
February 1982	23	1,002
March 1982	32	1,699
April 1982	36	2,233
May 1982	30	732
June 1982	72	640
July 1982	26	402
August 1982	20	904
September 1982	16	393
October 1982	37	465
November 1982	45	589
December 1982	40	810
YEAR END TOTAL	462	11,780

COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

Referrals to In-patient Treatment Facilities
(July 1981 to December 1982)

JULY 1981

Winnebago - 2
Jamestown - 3

AUGUST 1981

Winnebago - 2
Jamestown - 1
Ft. Meade - 1

SEPTEMBER 1981

Jamestown - 3

OCTOBER 1981

Jamestown - 2
Aberdeen - 1

NOVEMBER 1981

Jamestown - 3
Ft. Meade - 1

DECEMBER 1981

Jamestown - 2
Ft. Meade - 1

JANUARY 1982

Jamestown - 4
Ft. Meade - 2

FEBRUARY 1982

Jamestown - 4
Ft. Meade - 3

MARCH 1982

Jamestown - 9
Ft. Meade - 2

APRIL 1982

Jamestown - 6
Winnebago - 1

MAY 1982

Jamestown - 4
Ft. Meade - 1
Sgt. Bluff- 1

JUNE 1982

Jamestown - 11
Ft. Meade - 2
Sgt. Bluff- 1

JULY 1982

Sgt. Bluff- 2
Ft. Meade - 2
Jamestown - 3
Fargo - 2

AUGUST 1982

Ft. Meade - 4
Jamestown - 3

SEPTEMBER 1982

Ft. Meade - 2
Ft. Totten - 1
Sgt. Bluff- 1
Jamestown - 3
Sheridan - 1

OCTOBER 1982

Ft. Meade - 3

NOVEMBER 1982

Ft. Meade - 2
Sgt. Bluff- 1

DECEMBER 1982

Jamestown - 10
Sgt. Bluff- 3
Winnebago - 1
Ft. Meade - 1

TOTAL REFERRALS - 121

COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

Expenditures Compared to Budget
October 1, 1981 - September 30, 1982

Contract No:	IHS CONTRACT 241-82-0084	IHS CONTRACT 241-81-0195	N.D. STATE 1605
Total Funding:	\$96,815.00 (+ '80 Carryover)	\$72,920.00	\$40,303.00
Expenditures:			7,655.94 (1st Qt)
OCTOBER 1981	6,491.48	1,348.03	1,518.69
NOVEMBER 1981	5,749.14	6,142.24	378.32
DECEMBER 1981	4,593.00	6,474.56	1,489.15
JANUARY 1982	3,694.43	3,683.64	1,869.19
FEBRUARY 1982	5,018.18	4,851.17	2,828.09
MARCH 1982	5,123.92	3,871.21	7,041.46
APRIL 1982	6,200.13	5,657.20	2,542.99
MAY 1982	6,095.71	7,038.87	3,660.51
JUNE 1982	5,756.38	7,950.72	4,118.56
JULY 1982	7,814.59	6,217.73	2,885.97
AUGUST 1982	8,950.98	6,432.45	2,115.79
SEPTEMBER 1982		12,252.18	3,694.34
SEPTEMBER 1982	24,643.60	CLOSED OUT	
	IHS CONTRACT 241-83-0020		N.D. STATE
OCTOBER 1982	2,626.16		2,687.07
NOVEMBER 1982	4,712.33		2,010.20
DECEMBER 1982	9,493.94		4,819.50
JANUARY 1983	5,098.60		2,173.90

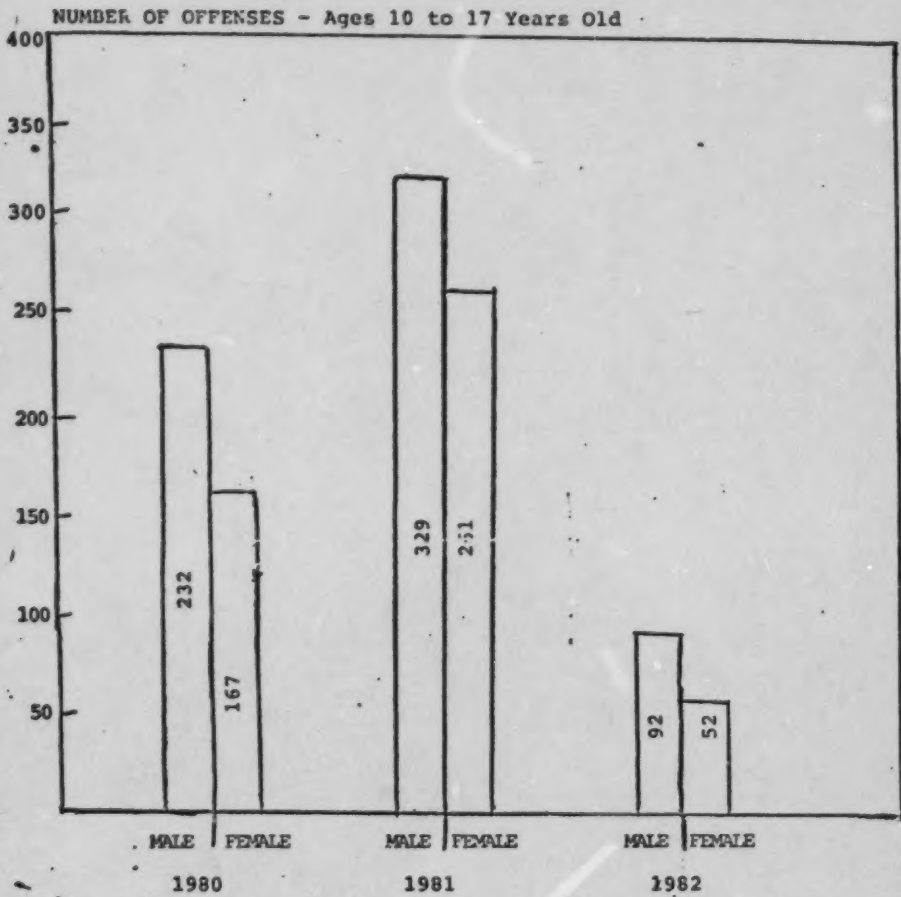
COMPREHENSIVE CHEMICAL PREVENTION PROGRAM
Standing Rock Sioux Tribe

Total In-Patient Admissions to Program
Districts of Standing Rock - 1973 - 1981

DISTRICT	FEMALE	MALE	TOTAL	ADMISSIONS
Bullhead, South Dakota	20	50	70	360*
Kenel, South Dakota	20	8	28	184*
Little Eagle, South Dakota	26	61	87	319*
McLaughlin, South Dakota	11	16	27	103*
Wakpala, South Dakota	13	42	55	77*
Cannon Ball, North Dakota	32	100	132	486*
Fort Yates, North Dakota	88	145	233	1,535*
Porcupine, North Dakota	0	5	5	17*
TOTAL -	210	427	637	3,081*

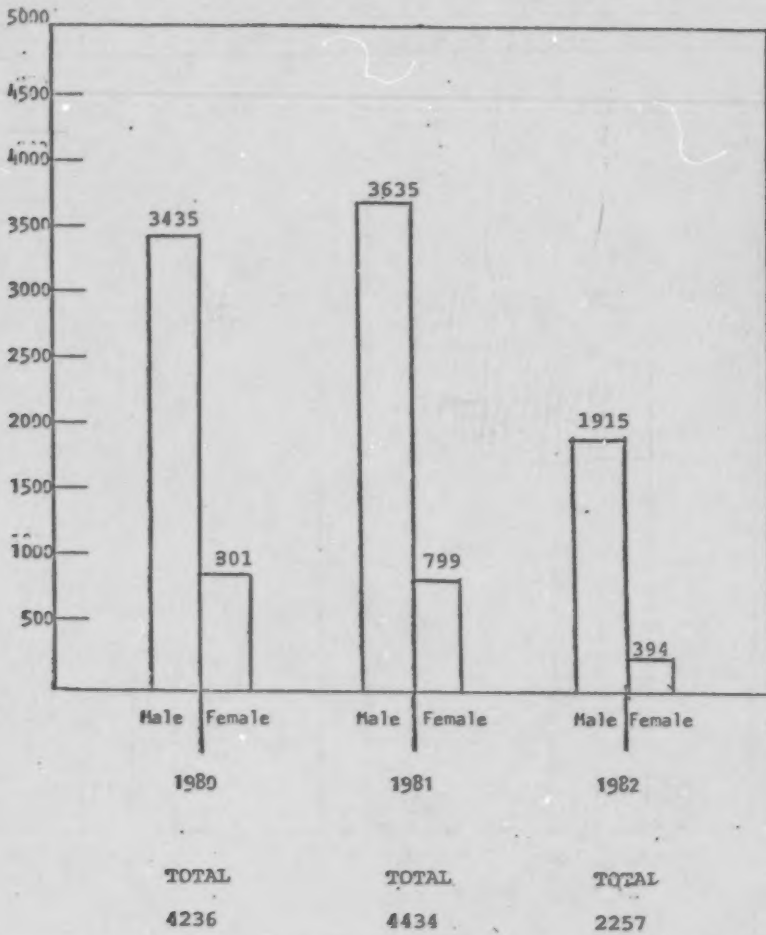
*The total number of admissions shows how many times the total (Female and Male), have been through the program.

STANDING ROCK SIOUX RESERVATION
Alcohol and Drug Related Offenses



MEAN - $399 + 590 + 144 = 1,133 \div 3 = 377.67$

MEDIAN - 399 144 399 590

ADULT ALCOHOL RELATED OFFENSESNumber of Offenses

RESOLUTION

NO. 26-83

WHEREAS, the Standing Rock Sioux Tribe is an unincorporated Tribe of Indians having accepted the Indian Reorganization Act of June 18, 1934, and the recognized governing body of the Tribe is known as the Standing Rock Sioux Tribal Council and

WHEREAS, the Standing Rock Sioux Tribe under its Constitution approved by the Secretary of the Interior on April 24, 1959, pursuant to Article IV Section I (c) through its Tribal Council has the authority to exercise various powers by enactment of an appropriate motion, resolution or ordinance subject to any limitations imposed by the Constitution of applicable statutes of the United States and

WHEREAS, the Standing Rock Sioux Tribe does express its concern and dedication to the improvement of Health Services for the people of Standing Rock and

WHEREAS, it is imperative that Congress be made aware of the impact upon direct services and patient care by the U.S. Public Health Service Unit at Fort Yates and

WHEREAS, the Health, Education and Welfare Committee of the Standing Rock Sioux Tribe has reviewed the proposed request for Special Appropriations to Congress, copy attached and found it acceptable and a priority and

NOW THEREFORE BE IT RESOLVED, that the Standing Rock Sioux Tribe hereby submits the enclosed request for Special Appropriations be made available by Congress and earmarked for the Fort Yates Service Unit in the amount of \$750,000 to be utilized within the attached budget breakdown and

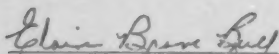
BE IT FURTHER RESOLVED, that the Chairman and Secretary of the Tribal Council be authorized and instructed to sign this resolution for and on behalf of the Standing Rock Sioux Tribe.

CERTIFICATION

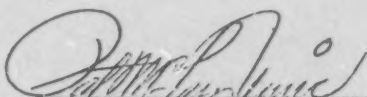
We, the undersigned Chairman and Secretary of the Tribal Council of the Standing Rock Sioux Tribe, hereby certify that the Tribal Council is composed of 15 members of whom 14, constituting a quorum were present at the Regular Meeting thereof duly and regularly called, noticed, convened and held on the 2nd day of February 1983, that the foregoing resolution was duly adopted by the affirmative vote of 11 members, with 0 opposing and with 2 not voting, the Chairman's vote is not required except in case of a tie.

DATED THIS 2nd DAY OF February 1983.

ATTEST:



Elaine Brave Bull - Secretary
Standing Rock Sioux Tribal Council



Pat McLaughlin - Chairman
Standing Rock Sioux Tribal Council

Request for Special Appropriations
Fort Yates Service Unit
Standing Rock Sioux Reservation
Fort Yates, North Dakota

Request to Congress for Special Appropriations be made available and earmarked for the Fort Yates Indian Health Service Unit, Standing Rock Sioux Reservation, Fort Yates, North Dakota.

Below you will find reasons for justifying such a request for additional monies:

1. INCREASE IN NUMBER OF PEOPLE TO SERVICE:
 - (a) Births over the past three (3) year period: 471 children born.
 - (b) Referrals made to other facilities for Specialized treatment and care over a three (3) year period: 2,556 patients referred.
 - (c) Migration back to the reservation due to cutbacks in Rural/Urban programs and the increase of unemployment over the past three (3) year period: The population has increased from 6,383 people in 1980 to 6,629 people in 1983 or 81.7 people per year.
2. Refusal of hospitals to allow a 10% discount for patients referred to their facilities for specialized treatment and care. High cost hospitals in this area.
3. Tremendous cutback on health insurance benefits, placing a burden on the Indian Health Service having to pick up the tab.
4. Restrictions for third (3rd) party eligibility, criteria so limited that Public Health Service is the only resource.
5. Shortage of Medical staff, results in alot of overtime being paid to existing staff and payments made for temporary staff is enormous.

The facilities on the Standing Rock Sioux Reservation consists of the following

- 1 - 32 bed hospital located at Fort Yates, North Dakota which consists of:
 - 4 - Doctors positions (unable to keep filled permanently because of isolation and rurality.)
 - 21 - Nursing Staff (need for additional nursing staff)
 - 1 - Dentist
 - 1 - Dental Assistant
 - 1 - Pharmacy
 - 2 - Pharmacists
 - 1 - Lab & X-Ray
 - 2 - Lab Technicians & X-Ray
 - 1 - Optometry Service
 - 1 - Optometrist
 - 1 - Dietary Service with Dietitian
- Outpatient and Emergency Room
- Pediatrics
- OB/GYN
- Facilities Management

There is definitely a need for additional personnel at the Fort Yates Service Unit which includes the need for a Midwife/Physicians Assistant, two (2) additional Administrative personnel and additional Nursing staff.

Health Center located at McLaughlin, South Dakota which is approximately 30 miles south of Fort Yates which consists of the following:

- 1 - Doctor full time
- 1 - License Practical Nurse
- 1 - Pharmacy with full time Pharmacist
- 1 - Lab & X-Ray with full time Technician
- 1 - Dentist & Dental Assistant full time
- 2 - Field Nurses
- 1 - Medical Records Clerk
- Administrative Staff & Staff Assistant
- Maintenance & Janitorial Services

3 - Field Clinics

- 1 - Field clinic is located at Cannon Ball, North Dakota which is approximately 27 miles north of Fort Yates, ND resulting in a 54 mile roundtrip. Outpatient services provided weekly with patients being referred to the PHS hospital at Fort Yates or other referral agencies as deemed necessary. 1 - Doctor, 1 - Nurse Practitioner, 1 - Pharmacists provide these services on a weekly basis.
- 1 - Field clinic is located at Bull Head, South Dakota which is approximately 44 miles south of Fort Yates, ND resulting in a 88 mile roundtrip. Outpatient services provided weekly with patients being referred to the PHS hospital at Fort Yates or other referral agencies as deemed necessary. 1 - Doctor, 1 - Nurse Practitioner, 1 - Pharmacists provide these services on a weekly basis.
- 1 - Field clinic is located at Wapakala, South Dakota which is approximately 50 miles south of Fort Yates, ND resulting in a 100 mile roundtrip. Outpatient services provided weekly with patients being referred to the PHS hospital at Fort Yates or other referral agencies as deemed necessary.

Transportation has become an important factor of our Service Unit because of the high increase in rental and mileage rates set by GSA. There has been an increase of 55% in mileage from 24¢ per mile to 38.5¢ per mile and an increase of 24% in rental.

Operation and Maintenance also has to be given a priority since there has not been an increase in the budget for O&M and the existing hospital has been in operation since October 1965 and is in need of some upgrading in maintenance.

Because of the increase in fuel and electricity over the past few years we are experiencing a higher cost for utilities and our budget simply cannot handle all the increases that have come about over a period of time.

One of the most important part of the hospital is the Pharmacy which has experienced an all time low in supplies, the high cost of drugs and other pharmacy supplies have sky-rocketed and it is almost impossible to maintain a sufficient amount of supplies on hand many times a patient has to be referred to a private drug store or supplier resulting in PHS paying almost double what the cost would be.

The need for additional medical staff, nursing staff and administrative staff plays an important role in our health delivery system and with the availability of additional monies this can become a reality and the quality of service would result in less turnover in staffing our facility.

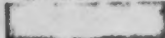
Below is a complete breakdown of what the additional monies would be used for:

ADDITIONAL BUDGET REQUEST BREAKDOWN:

\$ 250,000	Requested additional monies be made available for Contract Health Service. Referrals made for Specialized treatment and care.
\$ 500,000	Requested additional monies be made available for Hospitals and Clinics, with the following breakdown in line items:
\$ 100,000	Supplies for Drugs, Lab and X-Ray supplies and other supplies as needed.
25,000	Transportation for staff because of the tremendous increase in GSA rental and mileage and to meet the required visits to Field Clinics and transporting of patients and Air Ambulance for extreme emergency cases.
50,000	Operation & Maintenance has had no increase over the past three (3) years and the building is now 17 years old and needs to be maintained properly.
35,000	Utilities has gone up to an all time high nation wide resulting in higher fuel and electric bills.
35,000	Other unforeseen costs, we have experienced some unexpected costs over the past years especially when an infant has to be referred and transported to a University hospital and a parent has to help with the escort and signing of necessary papers.
255,000	Additional staffing would result in a better delivery of services to the people of the Standing Rock Reservation which is the main goal of the Standing Rock Sioux Tribe as well as the US Public Health Service Unit.
\$ 750,000	Total amount requested from Congress for Special Appropriations to the Fort Yates Service Unit.

CAROL USES ARROW

CHR Coordinator



DEPT. OF TRIBAL HEALTH
Fort Yates, N.D. 58538
Telephone No. 854-7231

COMMUNITY HEALTH REPRESENTATIVE PROGRAM

The Community Health Representative Program is designed to deliver Outreach Health Care and Health Education by communicating with local people, making home visits, providing maternal and child health information and providing assistance on general health care to the people.

The CHR's deliver prescriptions to people who need medication, recommended by a physician and who have no means of transportation to come to the IHS Pharmacy to have the prescription filled.

The CHR's provide follow-up and in-home care for the elderly, disabled and many other people needing medical attention.

The CHR's work closely with Indian Health Service, Police Department, Ambulance Service, Social Services, Mental Health and Alcoholism Programs on coordinating and assisting in decisions affecting the health care of the people.

They are trained in the field of Emergency Medical Services to provide immediate on-the-scene care until help arrives or transportation is made available to any emergency facility.

The CHR's are community people from the various districts on the reservation so they are able to help the people much more than someone coming to the reservation offering any type of service.

The following are statistics of health care services provided by the CHRs in each District on the Reservation.

COMMUNITY HEALTH REPRESENTATIVE PROGRAM

These figures are for the period of October 1, 1981 to September 30, 1982.

HEALTH CARE SERVICE	BH	CB	FY	KL	MCL	LE	SH	WK	TOTAL
Accident & Injury	46	37	17	24	18	17	17	30	206
Administrative Activities	7	3	76	28	19	2	0	27	162
Alcoholism & Drug Abuse	39	9	21	66	16	7	6	6	170
Audiology	1	8	511	0	0	0	0	2	522
Cancer	1	0	0	0	1	1	0	0	3
Clinical Assistance	389	560	15	0	0	44	0	236	1244
Communicable Disease	106	16	2	0	0	0	2	23	149
Comm. Health Nursing	32	2	8	77	2	36	0	25	182
Dental	35	10	7	31	19	6	2	13	124
Diabetes	136	102	52	86	34	30	20	44	504
EMS	23	61	5	6	9	15	18	10	147
Environmental Health	0	3	0	0	8	1	25	7	43
Eye Care	25	19	11	215	19	1	4	42	336
Health Education	71	53	32	24	39	28	8	35	290
Heart	39	16	9	34	26	7	8	3	142
Home Accidents	13	24	13	5	6	14	11	27	113
Home Maintenance	14	0	5	0	0	0	0	0	19
Hypertension	68	167	24	55	27	7	49	106	503
Interpret	2	0	2	12	0	0	10	0	26
Maternal Child Health	532	384	26	68	15	115	13	487	1640
Medication Delivery	73	51	64	125	46	56	16	144	575
Mental Health	14	40	0	102	2	5	1	2	166
Motor Vehicle Accidents	4	14	1	3	1	1	6	0	30
Nutrition	31	58	3	0	32	0	0	3	127
Nursing (RN & LPN)	2	0	0	0	0	0	0	0	2
Nursing Home Care	21	10	21	6	0	9	0	8	75
Patient Referral	33	60	41	33	16	2	4	38	227
Physical Therapy	1	7	0	0	0	0	0	0	8
School Health	2	24	1	11	1	6	2	38	483
Senior Citizens	66	39	72	54	143	7	9	28	418
Social Services	36	30	50	22	79	15	0	6	238
Patient Transport (Non-Emergency)	53	48	59	157	91	26	10	24	468
	1916	1855	1148	1244	669	458	241	1414	8944

The Community Health Representative Program is considered to be the vital link of health care services on the reservation because of the distance to reach any health care facility. Without the services the CHR's provide health care on the reservation would diminish.

The Community Health Representative Program is one of the best programs on the Reservation because it has improve the health of many people and saved lifes as while.

The CHR Program also provides direct eye care services to the people. These services include: fitting & adjusting eye glass frames, eye screening and

COMMUNITY HEALTH REPRESENTATIVE

making appointments. For the period of October 1, 1981 to September 30, 1982, 2,550 people were examined for eye care.

The Community Health Representative Program provides Ambulance Attendants/EMT Personnel and the funds required for partial Ambulance Service operation.

Senator ANDREWS. Our next group of witnesses are: Roger Jourdain, chairman of the Red Lake Band of the Chippewa Indians; Dr. Clark Marquart, medical director of the Indian Health Management; Arta Carlow, the president of the Tribal Health Authority of the Oglala Sioux Tribe; and Lois M. Fallis, the chairman of the South Dakota Urban Indian Health, Inc. Those four would—or do we have just two? What is happening over here?

Mr. JOURDAIN. I have my staff members here. This is for you. This is a book on Indian treaties. That is my picture there.

Senator ANDREWS. That is your picture? Gosh! You were charming when you were young. Roger, would you like to go first?

**STATEMENT OF ROGER JOURDAIN, CHAIRMAN, RED LAKE
BAND OF THE CHIPPEWA INDIANS**

Mr. JOURDAIN. OK. I appreciate this. Thank you, Senator. I have been looking forward to your field hearing for some time.

Way back, we asked one of your colleagues on your committee, John Melcher, to hold a field hearing but he insisted on having it in Billings. Apparently he did not fly.

But the Indian tribes across the country, I believe, can provide a lot more input in the field than they can down in Washington, D.C., because of the time constraints we are always up against. So, with this first field hearing that I am attending, I certainly want to say thank you from the Red Lake Band of Chippewa Indians which consists of 7,270. We have the correct enrollment census because of the coming of the claims distribution. It always makes it easier when you have a census.

Senator ANDREWS. Well, it always makes it easy when you send those care packages of wild rice to my wife. You really capture our fancies.

Mr. JOURDAIN. That is an old Red Lake Chippewa custom.

Senator ANDREWS. You will almost get yourself to be an honorary custom in North Dakota.

Mr. JOURDAIN. Well, I will tell you how we got over here. I want to explain. We had to hijack the plane under the cover of darkness to come over here to North Dakota.

Senator ANDREWS. I hope they had fuel in that airplane.

Mr. JOURDAIN. We just got enough. We asked them when we got off. They have fuel now.

Some years back when we were under the area office of Aberdeen, Dr. Browning manipulated us politically by having an advisory board and they always referred to us as the Indians on the east side of the river. So I am glad to be on the west side of the river to see these Indians over here and I certainly want to share with them their major concern of their Indian health problems. I am fully aware of what they are up against and I certainly felt sad about their stories. They have not been allowed to exist in this country.

Senator ANDREWS. Is it any better on the Red Lake Band's Reservation?

Mr. JOURDAIN. Yes; it has improved considerably with a new facility. It has provided a much better preventive care and the tribal council itself has provided additional transportation so that the transportation can be readily available when the sickness develops in the early stages.

Years back, in 1954, the first public health doctor came in and he scared everybody away from the hospital because he came out of Chicago. He was a highfalutin, sophisticated, Chicago product, under Al Capone, I presume, but he came in there and he said, "I am the boss, and I will charge you up to a hundred dollars," and he scared everybody out. So he came to me. I was a postmaster and I was starving behind that cage for 3 or 4 years, but nevertheless, Dr. Grice came to me. He said:

What is wrong with your people, Roger?

I said:

You have them scared. You have no rapport developed. You have come in here out of Chicago and you are just an ophthalmologist. You are telling us what you are going to do instead of trying to encourage a better working relation with the Office of Indian Health Service.

So, he finally mellowed down and he came back to Earth. He began to work with the different groups and the different parts of the reservation.

But, it improved considerably after that because of the comprehensive health service we have providing a supplement to the Indian Health Service, which is out in the field all the time, and we have a director here, Monty Hammet, and his assistant Robert Togafer, and the highjacker Warren Bogil, and so we have made considerable progress in the field of health.

But, what we are concerned about in the main is the funding level. We are all being threatened with cutbacks. I think they should at least maintain the existing level because, as it has been said here before me, there has been an investment made and we are just now getting to a certain standard of improvement of our Indian health. Now we are talking about cutbacks in every department.

But coming back over to the delivery of services, I want to hit very plainly in the—that is the office of Dr. Rhoades, Indian Health Director, Washington, D.C., or now Rockville. He has his hands tied. He spends more time answering to these multiple layers of people that he has to deal with in the IHS until he gets up to the Secretary's office. The National Tribal Chairman's Association and all the Red Lake Tribal Council went on record recommending the elevation of that office to Assistant Secretary. Let him be the master and the leader of the Indian Health Service without interference. He is a real dedicated advocate for the Indian Health Service for the Indian people. I had an opportunity to meet with him a couple times and he impressed me a great deal with his serious concern for the Indian Health Service. In the coming future, I would strongly recommend that. It is in my statement here and I also included an NTCA statement recommending that.

Senator ANDREWS. Great.

Mr. JOURDAIN. And so, you better have your staff member take a hard look at it and introduce a bill immediately to elevate that office. That would help.

Senator ANDREWS. A major point. Let me assure you, Mr. Chairman, that every one of those words that you wrote out in that excellent statement will appear in the record.

Mr. JOURDAIN. All right, sir.

[The prepared statement follows. Testimony resumes on p. 154.]



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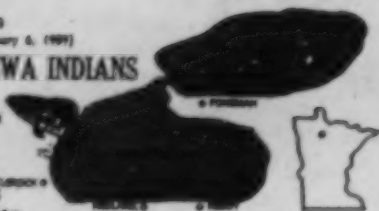
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RED LAKE BAND of CHIPPEWA INDIANS

Phone 218-836-2801
 RED LAKE, MINNESOTA 56571

Field Hearings on IHS
 Grand Forks, North Dakota
 June 2, 1983



(Senator Mark Andrews Presiding)

Statement By
 Roger A. Jourdain
 Tribal Chairman
 Red Lake Band of Chippewa Indians

In reflecting upon my more than 24 years of experience as Tribal Chairman for the Red Lake Band of Chippewa Indians and serving on most all National Indian Associations, I find that there has been tremendous progress in meeting the goals of the highest possible level of health care for American Indians. However, we still have major concerns which, if not effectively resolved immediately, threaten to delay, and reverse, the progress that has been gained toward our goals. And in my opinion as Tribal Chairman, let me briefly review the progress to date. There is no question that the health status and health care of the American Indian has dramatically improved during this period. Infant mortality, is the lowest it has ever been on our reservations. Maternal mortality, which was once more than twice the US rate, has been less than the US rate for the past several years. Infectious diseases, once the leading cause of American Indian deaths, have been substantially reduced.

Several factors make the Indian Health Service and the Tribal health goals attainable for raising the health status and health care of the American Indian to the highest possible level. I would like to mention just a few of these critical factors for Red Lake.

— RED LAKE ENTERPRISES —

Red Lake Indian Sawmill (72 Years) / Red Lake Cedar Fence Plant / Chippewa Arts & Craft Shop
 Red Lake Housing Industry / Red Lake Fishing Industry (89 Years) . . . Home of the Famous Red Lake Walleyes

1. The most critical factor is the funding for the Indian Health Service (I.H.S.) programs and operations. The I.H.S. budget must be maintained at an optimum level and this level is approximately 850 to 900 million dollars. The budget will dictate the quality and quantity of Health Care that American Indians will receive. As mentioned, our Health status and Health Care is being threatened if not reversed by the dramatic reduction in funding, if this were to continue, than all of our efforts, those of Congress, Administrations, and Tribal Leaders over the years will have been to no avail and we as Indian people will be back to where we were 50 years ago. This we cannot let happen.
2. Advanced Housing improvements and new homes have been a critical factor, we have had a tremendous increase in the number of families moving back to our Reservation. Also attributable to the growth is the increase in Red Lake membership. From June 1958 to April 1983 our Red Lake membership has increased 48.78% or from 3,701 members to 7,226 members. We are currently serving approximately 5,000 persons here at our health facilities.
3. The Comprehensive Health Services program which is tribally operated has been a tremendous factor. The C.H.S. is a supplement to the I.H.S. in providing direct preventive patient care in the homes and community. The C.H.S. has total responsibility for all Community Health Nursing functions which are integrated with the inpatient and outpatient activities of the Service Unit. . We maintain the highest health levels possible in providing immunizations, screen clinics, referrals, discharge planning, in home treatments and consultation, and the Emergency Medical Services.

3. Through these activities we have reduced mortality and morbidity among our Indian people. The Tribal health provides the most vital linkage between the patients and the I.H.S., but is integrated as one Health Care Delivery System.
4. The new Health Facility is also a major factor, we are now able to attract greater quality of Health Care providers and a greater number of our members are now seeking out and using the new facility. However, we are deeply concerned in being able to maintain a high quality of Physicians and recommend that permanent Physicians be established and that pay scale be equal to the Private Sector.

Yet, there are major health problems remaining - problems which to a large extent are more complex than the infectious diseases. These are health problems which have major initiating or contributing factors in the social, economic and educational environment of the American Indian and of our community. Prominent among these health problems are the chronic diseases, mental illness and alcohol abuse which leads to accidents, homicide, suicide and neglect. Further dramatic advances in Indian health will come only when these root causes are eliminated but, not exclusively through the provision of medical care. I must, however, point out that access to high quality medical care remains absolutely essential to the maintenance and improvement of our health. It should also be noted that the advances made in the past were not due exclusively to medical care but depended to a large extent on the collaboration of American Indian individuals, families, communities, and Tribal Councils.

We still have two major areas of concern. 1) the extent of the Federal commitment to American Indians in general and to their health in particular and 2) the ability of the Indian Health Service to effectively manage health programs. The Federal commitment appears to be substantial and clear. The landmark legislation of the 1970's (the Indian Self-determination Act, PL 93-638 and the Indian Health Care Improvement Act, PL 94-437) firmly established in law the Federal responsibility for supporting American Indian self-government. Our opportunities to manage our own health programs and to provide the necessary resources to provide an adequate Indian health care delivery system. Unfortunately, the tangible actions of the Federal government have not matched the vigor of its words. The Indian Health Service has over the years generally proposed budgets which would provide adequate funding level requirements to maintain services and provide for improvements, but the Administrative levels above Indian Health Service have predominately reduced the Indian Health Service proposed budgets, which substantially reduces the requirements to maintain adequate services, or improvement, and in facts impedes the progress and treatment for Indian people. "Each year Indian health facilities, whether operated by Indian Health Service or by the tribes, must "absorb" major cost increases when funding levels fail to keep pace with inflation. For example, in Fiscal Year 1984 the Administration is requesting an increase in contract health services funding of about 6.6%, yet during the past year the actual cost of such health services in the private sector went up 13.6%. Example after example could be provided, all of which would show the failure of the executive branch to realistically support the Federal responsibility for Indian health."

Fortunately, the Congress has taken a much more serious view of the Federal commitment and has annually increased and improved the Administrations' budget requests. In fact, it is my belief that it has been this firm expression of Congressional support to the leaders of the American Indian communities and to the staffs of the tribal and IHS health programs that has maintained the morale and the initiatives which have resulted in the dramatic improvements.

"In spite of Congressional "add-ons", however, the inevitable result of the basic failure to provide realistic budgets has been an erosion of the ability of IHS and the tribes to provide health services. Accentuating this problem is the fact that, as purchasing power erodes, the highly qualified professionals who are essential to provide health services become discouraged and leave. It has only been through the exceptional performance of IHS and tribal health staffs that these health status improvements have been made in spite of marginal funding and frequently grossly inadequate health facilities."

Another trend that is now becoming apparent is the declining tribal interest in assuming responsibility for our own health programs. The reason is obvious - we as Tribal leaders are responsible for the health of our members. We cannot advocate taking over an underfunded and probably declining health operation by current trend. The funding levels need to be restored. If adequate funding levels cannot be maintained then the final result will be a reversal of the long trend of improvement in the health status of American Indians and in tribal assumption of our health programs, and the loss on the investment in health and in Indian self-determination that has been so difficult to achieve.

Another major area of concern relates to the ability of IHS to effectively manage the complex health and Indian self-determination programs, not only to provide high quality health services that are accessible and acceptable to us, but also to support and encourage the health programs operated by our tribes. The basic problem here, as stated earlier is in my judgement, the complex layers of management in the Department of Health and Human Services and the low status, both of organizational level and of attention - given to IHS. It seems that the decisions within DHHS are not always in the best interest of the American Indian. Consideration is rarely given to the fact that these decisions may be quite inappropriate to the needs of our Indian communities served by IHS.

"For example, various personnel freezes and ceilings have become almost routine - yet if nurses, technicians and doctors leave an Indian hospital or clinic and cannot be replaced, how can essential health services be provided?" The same vicious circle begins again: as highly trained professional staff leave and cannot be replaced, those remaining find it more and more difficult to maintain their standards of professional service to patients. At some point, their tolerance for declining quality is reached and they also leave. The cycle accelerates until a crisis is reached with hospital beds and/or clinics closed, patient care compromised - then, and unfortunately only then, exceptions are made for IHS. Many examples can be given where it is difficult to recruit and health professionals have been lost because of personnel freezes. Artificial personnel ceilings are forced; as a result, health services to Indian patients must be deferred or denied - or contracted out at much higher cost thus defeating the

supposed cost-saving purpose of the ceiling." IHS is the only substantial provider of direct health services to communities in DHHS and simply cannot be treated as if it were just another "money-changing" operation.

I referred to the lack of funding of Indian health. This may also be due to the multiple levels of management with DHHS which I mentioned. The decision-makers in the Office of The Secretary make their decisions based on reviews by these multiple layers of management." At one time, I noted 38 individuals who reviewed the IHS budget request between the IHS Director and The Secretary. Many of them, I'm sure, knew little or nothing of the realities of delivering health services" in Red Lake or of Alaska, or the deserts of Arizona. One thing is certain, much of the reality of the needs on Indian people is lost in the translation of multi levels of management.

The Director of IHS must spend an inordinate amount of time dealing with these layers of management within the department, thus diverting his attention from the basic management of IHS. This not only creates problems at the Headquarters office, but limits his availability to work with the field staff and the tribal leaders.

Based on the nature of the problems, I would respectfully recommend to the Congress that attention be directed toward resolving these problems. In the short-term, immediate review of the current (FY 83) funding levels of the IHS should be carried out with supplemental funding assuring that present levels of service can be maintained and function appropriately. We strongly urge an amendment to the IHS budget of approximately 150 million dollars which will restore the last three years of budget cuts. This will solve the problems of personnel, contract care, and Tribal contracts, supplies, and training.

In addition, bill language should be inserted to assure that the Indian health programs function as directed by the Congress. Administration directives, personnel freezes, ceilings, interminable delays of patient care and endless reviews, should not be permitted to frustrate the will of the Congress and Tribes.

In the longer term, I recommend that Congress come to grips with the size and the scope of the Federal commitment to Indian health and the American Indian for example, who should be served (currently there are four different definitions of Indian in the laws governing IHS) and to what extent should services be provided. I'm suggesting here that Congress insert language in the bill which would authorize all Federally recognized Tribes to establish their own criteria as to whom health services be provided through the support of the Federal government. If this were done, Indian health budgets could be more realistically developed and both the tribes and the Congress would know what to expect.

It is extremely important that Congress initiate the actions necessary to reauthorize PL 94-437. I would strongly recommend and urge Congress to change the language on the uses of any and all Third Party collections i.e., Medicare, Medicaid, private insurances etc., to read that any and all Third Party dollars collected by IHS or the Tribes are to be supplemental and not supplanting dollars to the IHS budget, and that the dollars collected by the Service Unit and the Tribes where collected to be used for Health Care at the discretion of the Service Unit and the Tribe. Additional language in the bill needs to be inserted, that no Indian person should be sent bills for his or her care that is the responsibility of IHS especially if the person is receiving services under contract health care.

Another important issue is equity funding. We strongly recommend that no Tribes should be cut in their funding to off set funding for other Tribes. Funding should be made available for all Tribes to provide adequate Health Care on our reservations.

Recently there was a task force report that come out from the IHS. It is our beliefs that the task force report was largely made up of individuals from outside the IHS or Tribes and more of a directive approach from higher levels. Again, we recommend that IHS take no action on implementation of this report until all Tribal leaders have had direct input and consultation. In fact, too many decisions are made at higher levels than the IHS that have direct effect on our Tribal operations without Tribal consultation, this is in direct conflict with PL 93-638 regulation and the intent of PL 93-638. There have been and is current proposals and legislation to remove the activities and function of Environmental Health and Sanitation out of the IHS. We recommend that all Environmental Health and Sanitation be left with the IHS and funded adequately.

Finally, we strongly recommend a statutory elevation of the IHS to the Assistant Secretary level within DHHS, as is presently true of the Indian programs in the Department of Interior. This would also help to alleviate many of the management problems of IHS by eliminating much of the bureaucratic layering in DHHS and by permitting the IHS Director access to the decision-making level of the Department.

"In spite of the problems noted above, the Indian health programs have been, as an editorial in the Washington Post Headlined, "a Federal program that works:. Dealing resolutely with the remaining problems will safeguard the investment already made and will, in fact, assure American Indian people their right to self-determination and to the highest possible health status."

Specific Issues concerning the Red Lake Band of Chippewa Indians, Red Lake, Minnesota: I would like to specifically request that the Senate and House Committees initiate the necessary action for the completion of our total Health Care Facilities here at Red Lake.

Due to the technical error in the appropriation language the Extended Care portion of the New Health Facility was not able to be constructed. From the on-set of all testimony given by the Congressional members of Minnesota in the Mid 1970's, the language used was the Red Lake Health Facility, but in final appropriation language it read "Red Lake Hospital."

The initial planning appropriations of \$450,000 included the Extended Care and all plans, blue prints, specifications were and have been completed as a total Health Care Facility.

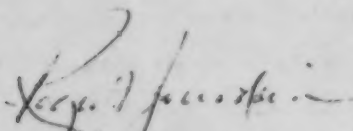
We are including as part of our testimony some of the documents regarding the Congressional interest which included the Extended Care.

Also, we would like to have the Committees approval for IHS to use Medicaid and Medicare funds for the Planning, Design, Renovation and Construction of our condemned Ponemah Clinic. Included is our proposal submitted to the IHS for this project.

Also, I am including the Statement on Critical National Indian Health concerns which was adopted by the National Tribal Chairmen's Association (N.T.C.A.). We fully support the N.T.C.A. position on these Health concerns.

Your assistance is greatly appreciated in helping us to achieve
Health goals of IHS and our Tribes.

Respectfully submitted,

A handwritten signature in dark ink, appearing to read "Roger A. Jourdain". The signature is fluid and cursive, with a long horizontal stroke at the end.

Roger A. Jourdain
TRIBAL CHAIRMAN

ATTACHMENTS:

- A. Extended Care Documents
- B. Ponemah Clinic Proposal
- C. N.T.C.A. Statement

EXTENDED CARE DOCUMENTS

STEWART E. TALMADGE, GA., CHAIRMAN
 JAMES D. EASTLAND, MISS.
 GEORGE MCCLINTOCK, N. CAR.
 JAMES D. HILL, ALA.
 ROBERT D. BARKER, TEX.
 WALTER D. DICKSTON, AR.
 BILL CLARK, WYO.
 MICHAEL B. STONY, FLA.
 PATRICK J. LEAHY, VT.
 MICHAEL R. MCLEOD
 GENERAL COUNSEL AND STAFF DIRECTOR

U.S. Senate
 EXTENDED CARE DOCUMENTS

COMMITTEE ON
 AGRICULTURE AND FORESTRY
 WASHINGTON, D.C. 20518

April 5, 1976

The Honorable Robert C. Byrd
 Chairman
 Subcommittee on Interior and Related Agencies
 Appropriations Committee
 United States Senate
 Washington, D. C.

Dear Mr. Chairman:

You will recall that \$450,000 in planning funds was appropriated in Fiscal Year 1976 for the Red Lake health facility at Red Lake, Minnesota.

The Senate, on March 9, agreed to disapprove the President's deferral of budget authority for Indian Health facilities. Now that these funds have been released, I want to be certain that the funding for the next phase will be approved by the Congress for each of these Indian health facilities. I understand that \$4.2 million is required in Fiscal Year 1977 for initial construction of the Red Lake health facility. I consider this a priority project and will appreciate the Committee's consideration of these Indian health facilities funds as it works on the Fiscal Year 1977 Interior Appropriations.

Best wishes.

Sincerely,

Hubert H. Humphrey
 Hubert H. Humphrey



2007年11月 20日 星期五 11:11:11 AM

COMMITTEE ON FOREIGN RELATIONS

June 3, 1977

Dear Mr. Chairman:

I especially appreciate your cooperation in helping us to plan the health facility at the Red Lake Reservation at Red Lake, Minnesota, through planning monies in Fiscal Year 1976.

The construction is scheduled to begin this summer but we have encountered a problem in the wording as it appears in the 1978 budget request. The Master Plan for the Red Lake Health Facility includes an extended care portion and we understand that the Indian Health Service cannot give a go-ahead on the construction for this portion even though they fully support and have included the Extended Care Portion in the planning monies for the facility. I understand that this technicality could be corrected and could be acceptable to IHS by modifying language in the Interior Appropriations Report to read "Red Lake Hospital Including Extended Care." I understand this would not require an increase in the FY 1978 appropriation.

Your assistance in including this additional language in the Report would be greatly appreciated.

Best wishes.

Sincerely,

Hubert H. Humphrey

HUBERT H. HUMPHREY
MINNESOTA

United States Senate

WASHINGTON, D.C. 20510

July 5, 1977

Mr. Monte Hammett
Director
Tribal Health, Indian Health
Services
Red Lake, Minnesota 56671

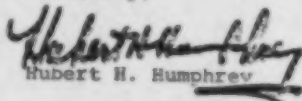
Dear Mr. Hammett:

Enclosed is a copy of the letter Mr. Gene Graves of my staff discussed with you.

As I stated in a letter to Roger Jourdian, the requested language "to include extended care" is addressed by the intent. The money is appropriated for initial construction of the entire facility which implies that the extended care portion is included.

Best wishes.

Sincerely,


Hubert H. Humphrey

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United States Senate

COMMITTEE ON
 GOVERNMENTAL AFFAIRS
 WASHINGTON, D.C. 20510

ROBERT A. STEVENSON
 CHIEF COUNSEL AND STAFF SECTION

March 22, 1978

The Honorable Robert C. Byrd
 Chairman
 Subcommittee on Interior
 Appropriations Committee
 United State Senate
 Washington, D. C. 20510

Dear Mr. Chairman:

With hearings scheduled this week in preparation for fiscal 1979 Interior Appropriations, we would like once again to call your attention to the Red Lake Hospital and Extended Care Facility, in Red Lake Minnesota.

As you know, Senator Hubert Humphrey was most concerned with obtaining funding for the entire facility during the past several years. With your support, and that of the subcommittee, the hospital is now well under way. We wish to extend our thanks to Mr. Dwight Dyer, of the subcommittee staff, who has been instrumental in defining the supportive criteria required to enable the initial planning for the extended care facility. You recall the efforts made to have the hospital and extended care facility defined as one.

We are enclosing a copy of a letter from the Red Lake Band of Chippewa Indians, identifying the specific appropriations required for fiscal 1979. We understand that all areas of the funding request have been discussed with Dr. Emory Johnson, Director of Indian Health Services. It is also our understanding that the analysis performed by Indian Health Services has shown the requested facilities to be justified and necessary, and the projected costs to be accurate and reasonable.

The President's budget request of \$900,000 for construction and equipping of the facility, does not approximate the funds needed to bring the project to a successful conclusion, nor does it address the extended care facility which we have so strongly supported. The arguments, benefits, and justification for the Red Lake Hospital have been made before. We merely refer the committee to the statements and testimony of the last several

years. Any deviation from the requested funds will serve only to extend the timing for completion of the badly needed medical center. With the funds already invested, and the escalating costs related to construction and equipment installation, any such delay will be costly, both economically and socially.

Some of the difficulties encountered during the fiscal 1978 appropriations discussions resulted from the lack of supportive data included in the IHS presentation to the subcommittee. Questions also arose periodically, regarding the procedures followed to support the finding and conclusions.

To avoid problems experienced in the past, we ask the committee's assistance in addressing the following questions to Indian Health Services:

- 1) Does the President's request for fiscal 1979 contain adequate funds for completion of the Red Lake Hospital Project?
- 2) Is the extended care portion of the facility defined as part of the current project under construction and is the planning completed?
- 3) Does the President's request include new positions for this facility? If not, how many positions are required?
- 4) Will there be any need for staff housing for the Red Lake project? If so, what is required?
- 5) The Red Lake Tribal Health Plan identifies a need for a replacement health center at Ponemah. Has IHS included sufficient funds for replacement of this badly needed facility?
- 6) It has been brought to our attention that the funding level for the Red Lake Comprehensive Health Program is inadequate. It is our understanding that this resulted from the fact that the initial transfer of funds from the Bureau of Community Health Services was understated. Because of this, Tribal employees are paid at a lower salary rate than federal employees performing similar functions. Does the 1979 budget contain funds to alleviate this problem? If not, what additional funding would be required?

With the cooperation of Congress and Indian Health Services, we believe that the Red Lake Hospital and Extended Care Facility,

and the Ponemah Health Center can become a model for other regions of our country, so badly in need of adequate health facilities.

We are also greatly concerned with the President's proposed cutbacks in funding for Indian Health Programs at the national level. These cutbacks amount to over \$15 million in the areas of IHS Manpower programs, the Tribal Health Program Development, Urban Health Programs and implementation of P.L. 93-638.

We would again like to ask the committee's assistance in determining the need for additional positions for newly constructed facilities that will be opened in 1979, and full funding of P.L. 94-437 as required and needed. In regard to these determinations, Dr. Johnson may be able to provide insight into some of the difficulties encountered in the utilization of the U. S. Bureau of Census population figures for health planning on Indian reservations. Because these figures provide the basis for funding numerous programs, reservation population data must be accurate.

We would greatly appreciate your consideration of these requests, and we are confident that Dr. Johnson's testimony will help to clarify some of the problems I have referred to.

Sincerely,

Muriel Humphrey

Muriel Humphrey

Wendell R. Anderson

Red Lake Band of Chippewa Indians
Red Lake, Minnesota

I. Equipment Red Lake Hospital:

1) Appropriations Required	1,330,000
2) President's Budget "79"	400,000
Balance Needed "79"	\$ 930,000

II. Skilled Nursing Unit:

1) To carry out original congressional intent, for clarification of language to include authorization and funding for the construction of skilled nursing unit which is an integral part of the total of facility.		
2) Appropriations required FY "79"	1,500,000	Construction
3) Appropriations required FY "79"	200,000	Equipment
4) Total Appropriation Required	\$1,700,000	FY "79"

III. Staff Housing

1) Total Housing Required	66 units
a) 2-6 plex; single bedrooms	12 units
b) 20 two bedrooms	20 units
c) 34 three bedrooms	34 units
2) Appropriations Required FY "79"	\$3,577,000

IV. Positions Required - Total 186 (Additional)

1) Appropriation Required FY "79"	1,240,000	62 positions
2) Appropriation Required FY "80"	1,240,000	62 positions
3) Appropriation Required FY "81"	1,240,000	62 positions

V. Staff Equivalence 1/

1) Appropriations Required FY "79"	233,000	Salary and Wages
2) Appropriations Required FY "79"	225,000	Retirement & Pension
3) Total Appropriations Required	\$458,000	FY "79"

VI. Ponemah Health Center

- 1) The complete replacement of the inadequate existing field health clinic. The replacement facility needs include the planning, equipment, and construction of a 5,500 square feet health center.
- 2) Projected costs and appropriations needed to provide for the services of dental, outpatient clinic, lab., X-ray, ambulance field health, and office space - \$500,000.
- 3) This meets the requirement of P. L. 94-437.

Summary of Total Appropriations Required FY "79"

I. Equipment	936,000
II. Skilled Nursing	1,700,000
III. Staff Housing	3,577,000
IV. Staff Positions	1,240,000
V. Staff Equivalence	458,000
VI. Ponemah Health Center	<u>500,000</u>

Appropriation Total FY "79" \$8,411,000

1/ V. Staff Equivalence

The staff equivalence was derived by the analysis of the HEW, IHS Evaluation procedures established by the Civil Service Commission for rating and job classification. The results of these findings show that the existing staff is being underpaid by \$233,000. Also, there is no allowance for retirement or pension funding for the above existing staff. It is estimated that a retirement/pension funding would amount to \$225,000.

RICHARD A. WEIDMAN
CHIEF CONSULT. STATE DEPT. OF CORRECTIONS

CHORP; P. M. P. M. V. H.
 JACOB M. H. H. P. P.
 W. L. H. V. M. P. M. J. M. P. M.
 P. M. P. M. P. M. P. M.
 C. M. M. M. M. M. M. M. M. M.
 J. M. M. M. M. M. M. M. M. M.
 M. M. M. M. M. M. M. M. M.

COMMITTEE ON
GOVERNMENTAL AFFAIRS
WASHINGTON, D.C. 20540

June 12, 1978

Dear Mr. Chairman:

In reference to our letter to you, dated March 22, we are providing additional funding requirements and supportive data based on conversations between our staffs and Mr. Dwight Dyer of the Appropriations Subcommittee staff.

We understand, as a result of a day-long meeting with representatives of the Red Lake Band of Chippewa Indians, GAO, PHS and IHS, that a serious breakdown in bureaucratic-congressional procedures within the Department of Health, Education and Welfare, has resulted in considerable confusion and loss of credibility in the justification for the Red Lake Hospital Complex that our two offices have worked for and supported for four years. The only losers in this procedural conflict are the people of Red Lake who have followed the direction of our offices and IHS to the letter. A great deal of time and money have already been expended for the project.

We are attaching a revised list of requirements, arrived at by general agreement between all parties to the meeting, and feel that the cost increase is adequately addressed and justified. We assure you that we understand the difficulties in obtaining supportive information and were not aware of the severity of the situation until the meeting of June 5, 1978. Red Lake has, however, acted in good faith and we are hopeful that the appropriations can be provided, contingent on the alleviation of similar problems in the future. We have made our feeling known to both PHS and IHS.

It is particularly important to point out that, in the spirit of Indian self determination, this is the first project planned completely by the Indians under P.L. 638. Again, all parties to the meeting were greatly impressed by the planning

procedures followed by Red Lake, and feel that it should prove to be a model for similar facilities throughout the United States in the future.

Also enclosed is a report done by IHS addressing the question of the "extended care facility." The report establishes a "needs" methodology for extended care. Although it is awaiting final approval within HEW, we feel it is important to pass it on to the committee in view of the communication problems currently being experienced.

We would greatly appreciate your consideration of these requests. The Red Lake Hospital Complex has been meticulously planned and with the enclosed square footage explanation we feel the immediate questions have been addressed.

Sincerely,

Muriel Humphrey

Wendell R. Anderson
Wendell R. Anderson

HUBERT H. HUMPHREY
MINNESOTA

United States Senate

WASHINGTON, D.C. 20510

July 5, 1977

Mr. Roger Jourdian
Chairman
Red Lake Board of Chippewa
Indians
Red Lake, Minnesota 56671

Dear Roger:

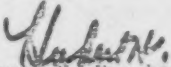
Attached is a copy of the letter received from Senator Byrd which you discussed with Gene Graves of my staff.

The question on the requested language "to include extended care portion" is answered by the intent. The money is appropriated for initial construction of the total facility which implies that the extended care portion is included.

I am pleased that I was able to help and please keep me informed of your progress.

With best wishes.

Sincerely,


Hubert H. Humphrey



PONEMAH CLINIC PROPOSAL

RED LAKE TRIBAL COUNCIL
INDIAN SELF-DETERMINATION CONTRACT (P.L. 93-638)
PROPOSAL TO INDIAN HEALTH SERVICE
FOR PLANNING, DESIGN, RENOVATION
AND CONSTRUCTION OF
THE PONEMAH HEALTH FACILITY
IN ACCORDANCE TO RESOLUTION NO. 117-81

I. General description of functions to be contracted. (Resolution No. 117-81)

Under the proposed self-determination contract the Red Lake Tribal Council will assume the full responsibility for the Planning, Design, Renovation, and Construction, as well as the administration and sub-contracting that is needed.

The scope of the work to be performed for the Ponemah Health Facility is as follows:

1. To develop plans and design the Ponemah Health Facility.
2. Engage the necessary sub-contractors that have experience and expertise in all necessary phases of the planning, design and construction.
3. Will administrate contract so that planning, design and construction is performed in accordance to all drawings and specifications and within the project costs as presented from the A/E, and DHEW.
4. The Ponemah Health Facility Project must meet and/or surpass all applicable codes, regulations, and requirements for a Health Facility.
5. Coordinate all planning, design, renovation and construction and equipment.

II. Type of contract.

Fixed price contract.

III. Proposed contract starting and completion dates.

Planning and design will begin immediately and construction will follow immediately after receipt of signed contract documents.

IV. Administrative space and administrative equipment needs.

N/A

The completion date will be established after receipt of A/E documents and construction schedules are approved.

V. Proposal narrative.

1. Experience and training of personnel and/or plans to recruit and employ qualified staff.
 - a) In carrying out the proposed contract, the Red Lake Tribal Council will be the directors and under their direct supervision the necessary qualified personnel will be hired.
 - b) The Tribal Council officers and members are experienced in directing and managing a wide range of complicated and complexed programs which included a number of construction projects and also the A/E contract for the Red Lake Hospital and Health Facility. Fiscally these projects exceed several millions of dollars annually.
 - c) The Tribal owned construction company will be the general contractor for the Ponemah Health Facility.
 1. The Construction Manager, Mr. Budge will be responsible to the Tribal Council for the overall construction of the project.
 2. Mr. Riley is the general supervisor of the Red Lake Construction Company.
 3. Mr. Andree will be the Job Superintendent for the Ponemah Health Facility.
 4. Our Accounting and Management System has been and is in operation that meets all accounting standards and will meet the requirements of the contract.
2. Sub-contracting
 - a) Standard and local practices will be utilized in selecting the most suitable sub-contractors in carrying out the requirements of the contract.
3. Familiarity with applicable federal regulations and/or ability to apply.
 - a) The tribe has reviewed and is aware of both the special provisions for Indian Self-Determination contracts described in Title 41, chapter 3, part 3-4, section 6011 and the general provisions for fixed price contract. In addition, the tribe will act to assure compliance with all construction codes and requirements for health facilities.
 - b) Since the Red Lake Tribe has operated contracts and grants from a variety of federal agencies in the past including Indian Health Service we foresee no problem in adhering to applicable regulations relative to Indian Self-Determination contracting procedures.

4. Experience in operating similar or related Tribal Programs.

a) The Red Lake Tribal Council has, as previously stated, sponsored, operated, and managed a wide range of programs and projects providing services, employment opportunities and facilities for members of the Red Lake Band of Chippewas.

b) Previous experience related directly to planning and construction of facilities includes the following projects:

<u>PROJECT</u>	<u>FUNDING SOURCE</u>	<u>A/E & CONSTRUCTION COST</u>	<u>PROJECT STATUS</u>
1) Modernization & Expansion of Red Lake Saw Mills Phase I (Engineering & Construction)	EDA	\$200,000	completed and operating
2) Modernization & Expansion of Red Lake Saw Mills Phase II (Engineering & Construction)	EDA	\$880,000	completed and operating
3) Red Lake Humanities Center (design, engineering & construction)	EDA HUD	\$868,800	completed 1975
4) Red Lake Public Housing: 215 Units (Construction)	HUD	\$2,859,000	completed in phases
5) Red Lake Fisheries (design, engineering & construction)	EDA	\$864,000	completed
6) Comprehensive Health Offices and Day Care Facilities (design, engineering & construction)	PHS	\$94,000	completed 1972
7) Red Lake Hospital & Health Care Facility (design, engineering & construction)	IHS	\$8,700,000	completed 1981

<u>PROJECT</u>	<u>FUNDING SOURCE</u>	<u>A/E & CONSTRUCTION COST</u>	<u>PROJECT STATUS</u>
8) Red Lake Hospital Staff Housing (design, engineering & construction)	IHS	\$2,400,000	completed 1981

Red Lake Builders, Inc. was the general contractor on the following projects:

1) Law and Order Center; Ponemah (BIA)	\$75,000	completed 1975
2) 50 Housing Units (HUD)	\$2,056,526	completed
3) Two (2) Youth Housing (BIA)	\$160,000	completed
4) Five - 6-Plex's (HUD)	\$2,000,000 approximately	completed
5) Community Centers in Redby & Ponemah	\$300,000 approximately	completed
6) Headstart Building, Ponemah	\$200,000 approximately	completed
7) Ponemah Sewer & Water Project	\$250,000 approximately	completed
8) 20 Housing Units (HUD)	\$1,407,000	completed
9) 58 Housing Units	\$3,915,590	now under construction
10) Ponemah Elementary School	\$1,725,730	now under construction

Red Lake Builders, Inc. has been a major sub-contractor on the following projects:

1) Red Lake Hospital (masonry work)	\$750,000	completed
2) Red Lake Hospital (finish flooring)	\$115,000	completed

5. Identification of federal employee transfers contemplated.

a) None.

6. Identification of Personnel System and Key Personnel.

As sponsoring agent for a number of programs and projects the Red Lake Tribal Council employs a staff of 100 including supervisors and field staff. A general personnel policy has been developed and is used for all tribal program staff.

7. Work Plan:

Immediately upon contract award the Red Lake Tribal Council will initiate management and supervisory procedures necessary to carry out the contract including:

1. Establishing special bank account.
2. See V-C - (1)
3. Legal aide and technical advice will be provided by the contracting manager, the tribal attorney, tribal architect.
4. Sub-contract for construction services. (See V-2-a)

VI. Evidence of Community Support.

1. The Red Lake Tribal Council consists of eleven elected members representing three major population districts on the reservation. Through this representative form of government, Indian people have historically been assured the opportunity to participate in the identification and solution of problems affecting their health and general welfare.
2. Indian self-determination has had the full support of tribal members for many years at Red Lake. This support is evidenced, in part, by the fact that the majority of planning and construction projects at Red Lake have been conducted through the Red Lake Tribal Council.

VII. Training to be provided for personnel performing under the contract.

1. Because of the nature of the project, no specific training is identified.

VIII. Number of Indians to be served.

1. The total Ponemah community approximately 1,000 members will benefit from the activities and results of the health facility.

IX. Proposed budget.

1. The proposed budget estimate is approximately \$35,000 for A/E and \$350,000 for construction and \$80,000 for equipment for a total of \$465,000.

X. Justification for advance payments.

The Red Lake Tribal Council does not have access to funds which can be used as interim financing for projects of this type. Basically, the council handles two types of funds; those funds which are identified as trust funds held in common for the members of the Red Lake Band and program funds which can be used only for the specific program for which the Government has designated the funds.

XI. Names of personnel to be contacted:

Mr. Roger A. Jourdain, Chairman
 Red Lake Tribal Council
 Red Lake, Minnesota 56671
 (218) 679-3341

Mr. Monte C. Hammitt, Project Director
 Red Lake Comprehensive Health Services
 P.O. Box 249
 Red Lake, Minnesota 56671
 (218) 679-3316

XII. Description of Tribal Organization.

1. Legal organization and/or relationship to Indians to be served.
 - a) The Red Lake Tribal Council is the duly recognized governing body of the Red Lake Band of Chippewa Indians.
 - b) Red Lake is a Federal Indian Reservation established by treaties of October 2, 1863 (13 stat. 667), April 12, 1864 (13 stat. 689), and the act of January 14, 1889 (25 stat. 642).
2. Description of Indian participation in tribal organization.
 - a) The Red Lake Tribal Council is a representative form of tribal government with Democratically elected council officers and members.
3. Evidence of Sanction or Control of applicant organization.
 - a) Tribal Council is the applicant for the proposed contract.
4. Election process for elected organizations.
 - a) Not applicable.

XIII. Liability Insurance Coverage

1. Liability insurance and other insurances common to the construction process will be furnished.

XIV. Financial participation by tribal organization.

1. There will be no financial participation by the Red Lake Band of Chippewa Indians.

XV. Specific request for waivers.

1. The Tribe will request waiver of any and all contracting and procurement laws which might inhibit its ability to successfully operate this Indian Self-Determination contract.

XVI. Specific request for advance payment.

A cash flow plan will be prepared and submitted. The advance payment amount will be requested for based on the first three months cash flow plan.

A cash flow plan will be developed and submitted.

A three months advance will be requested on the cash flow plan and an advance will be needed for three months of the second phase.

XVII. Attached is Resolution No. 117-81.

OFFICERS
 ROGER A. JOURDAIN, Chairman
 ROYCE GRAVES, Sr., Secretary
 MELVIN LITTLEHOCK, Treasurer

DISTRICT REPRESENTATIVES

LOIS ANGLAND JR.
 ANTHONY C. LUTZ
 CAROL A. LUTZ
 ANTHONY ELBERT
 GERALD SHAW
 JAMES A. LUTZ JR.
 JAMES L. LUTZ
 ANTHONY C. LUTZ

ADVISORY COUNCIL

FRANKLIN CHIEFS
LEGAL COUNSEL
 EDWARD S. STUMPF, Esq.
 DULUTH, MINNESOTA

Organized April 18, 1918
 (Revised Constitution and By-Laws January 6, 1957)
RED LAKE BAND of CHIPPEWA INDIANS

Phone 213-679-3041
 RED LAKE, MINNESOTA 55571



Res. No. 117-81
 Page two

RESOLVED FURTHER, that the Red Lake Tribal Council hereby authorizes the Tribal Chairman and Tribal Secretary to sign all necessary documents relative to the Ponemah Health Facility.

FOR: 9
 AGAINST: 0

We do hereby certify that the foregoing resolution was duly presented and enacted upon at the Regular meeting of the Tribal Council held on Thursday, September 3, 1981, with a quorum present at the Tribal Office, Red Lake, Minnesota.

Roger A. Jourdain
 Roger A. Jourdain, Chairman

Royce Graves, Sr.
 Royce Graves, Sr., Secretary

RED LAKE, MINNESOTA

Red Lake - Cotton Fence Firm
 Red Lake - Pottery Shop, 107 Years
 Chippewa Arts & Craft Shop
 Home of the Famous Red Lake Wabigoon

N.T.C.A. STATEMENT



NATIONAL TRIBAL CHAIRMEN'S ASSOCIATION

STATEMENT ON CRITICAL NATIONAL INDIAN HEALTH CONCERNS

The National Tribal Chairmen's Association (NTCA) and the American Indian tribes and Alaskan Natives want nothing more or less than those benefits promised them by the U.S. Government in exchange for their lands and resources. Among these benefits is the provision and conservation of health care which has been primarily provided through the Indian Health Service (IHS).

Every federal administration has provided IHS with too few dollars to even equal the previous year's level of health service, while costs for these services climb steadily upward. IHS is on the bottom rung of a multi-layered bureaucracy whose management and policy decisions on Indian care do not reflect any understanding of the constituency's real and unique health needs.

Existing health barriers such as chronic diseases, mental illness and alcohol abuse are escalating in Indian country aggravated by the cuts in federal program budgets which have caused the highest unemployment rate in recent years among Indian people. In some places it is now as high as 90%. Consequently, Indian people are still virtually at the bottom of all national health indicators with skyrocketing rates in accidents, suicides, homicides and neglect. Twice as many 25 to 34 year old Indians die from diabetes as non-Indian people. Among Navajo people average life span is 42.4 years compared with 65.1 years for the U.S. non-Indian population. Indian individuals die from cirrhosis of the liver 14.5 times as often as the 4.2 death rate for non-Indian citizens from ages 25 to 34 years. With no tax base in most Indian country communities, there exists no private sector to balance health care funding now being withdrawn by the federal government. States who are being asked to take over health services for Indians are refusing because their budgets are too small and because they feel it is a federal

responsibility. The results are rising unnecessary death rates and an ever tightening spiral of pressure on tribes and the IHS health system causing: loss of tribal interest in taking over underfunded and shrinking health systems; escaping health providers who are burned out, with no job security who have had to compromise quality patient care; threatened closure of needed health facilities and loss of vital preventative health/home care providers; exhaustion of medical supplies and curtailment of emergency hospital services halfway through the year.

Currently the IHS is being mandated by the Administration to redesign its programs for short-term savings without a realistic look at the long-term picture in Indian health care. This short-sighted approach must be stopped and replaced by a strategy which truly is designed to meet Indian health needs.

NTCA recommends that the following issues be addressed immediately by American Indian /Alaskan Native (AI/AN) Nations, the Administration and Congress:

Statutory Elevation of the IHS within the Department of Health and Human Services

NTCA insists that the Secretary of Health and Human Services elevate the position of the IHS Director to that of Assistant Secretary within the Department. Such action would provide IHS with the decision making power it desperately needs to justify and defend its budgetary, staffing and Indian health program needs before the administration and Congress.

Eligibility for IHS Service

NTCA recognizes the necessity for a comprehensive review of eligibility requirements for IHS services. A rapidly increasing service population, reductions in appropriations, inflation and reduced access to Medicaid and Medicare services have all contributed to a reduction of IHS/Tribal health delivery capabilities. Also, Congressional definitions of Indian for purposes of eligibility have been grossly inconsistent complicated by the lack of definitive standardized interpretations of eligibility requirements by the IHS Central Office.

NTCA, in concurrence with the findings of the IHS Contract Health Task Force, recommends the following:

1. That the eligible population for IHS supported services be clearly defined as only those Indians (a) who are members of federally recognized tribes; (b) who live in a clearly defined IHS/tribal service area; and, (c) who formally enroll for IHS services.
2. That the federally recognized tribes themselves determine who their members and eligible IHS service populations are.

NTCA adamantly opposes the administration's recommendation that IHS define its service population for Indian people based on a one quarter (1/4) degree blood quantum, as recommended by the President's Private Sector Study on Cost Control. We suggest that the use of blood quantum would present a considerable administrative problem of verification due to inevitable differences between tribally-set membership criteria and IHS service eligibility blood quantum level requirements.

NTCA therefore takes the position that each tribe separately should be responsible for determining whether or not to use blood quantum as a determinant of eligibility for direct and/or contract health care. It is also NTCA's position that uniform eligibility requirements for direct and contract health care are absolutely necessary in combination with an enrollment system, to eliminate the inappropriate distinction between service populations.

NTCA Indian Health Advisory Council

It is the position of NTCA that IHS should recognize the authority of the tribal governments and their authorized representative, NTCA, and provide this organization with a contract to perform the duties of a Tribal Health Advisory Council which would include liaison and all other activities usually performed by IHS area health boards. This would give IHS a greatly needed method of consultation with tribally authorized health advocates on major policy, budgetary and programmatic issues, and would provide the tribal liaison no longer made available by IHS under its proposed discontinuation of grants for tribal health advisory boards and health communications networks. NTCA already has an ad hoc Health Advisory Committee in place consisting of tribal health experts to act as the core body of such Tribal Health Advisory Council.

FY'83 IHS Funding Shortfall

While IHS awaits congressional decision on its \$19,359 million requested FY'83 supplemental funding, it still needs an additional \$37 million for this fiscal year if facilities are to remain open and critically needed services are to continue. Examples of the severity of need abound throughout Indian country. The Albuquerque Service Unit has already exhausted all contract care dollars and cannot treat any hospital emergencies except obstetrics. No new end-stage renal dialysis patients can be funded in the Phoenix area and those currently being served are threatened with loss of services if the Area Office must implement its cost containment policy set early this year.

It is NTCA's position that nothing short of a full \$57 million supplemental appropriation to IHS by Congress will suffice. Otherwise, the very foundation of many IHS/tribal health programs will crumble. This supplemental must become part of the recurring base allocated for FY'84 to avoid another critical shortfall and need to lay off or terminate even more IHS professional staff at the beginning of that fiscal year, only four short months away.

As a direct result of the FY'83 IHS funding shortfall, Lawton Public Health Service Hospital is threatened with closure by mid-August. Hospital supplies are now about depleted with a severe cutback in provision of high-cost prescriptions and over-the-counter medicines. The seven tribes served by that facility have requested relief through the following three measures: 1) that the Oklahoma City IHS Area Office be authorized to temporarily reprogram funds currently held frozen by the Department of Health and Human Services' mandated personnel hiring freeze, to purchase urgently needed supplies for Lawton Hospital; 2) that the Oklahoma City IHS Area Office be granted temporary authority to furlough employees for not more than twenty-two (22) days per employee, as necessary, to immediately avoid the end-of-year funding shortfall; and, 3) that Congress provide a supplemental appropriation of \$450,000 earmarked for the Lawton Service Unit to cover unmet health needs of its service communities within FY'83.

NTCA fully supports the request of these seven affected tribes and insists that the Department of Health and Human Services and the IHS immediately and positively act upon it in consultation with these tribes.

Urban and Rural Indian Health Care

NTCA takes special note of P.L. 94-437, Title V and the subsequent amendments of Title V addressed in P.L. 96-537. These acts clearly establish three distinct categories of Indians (federal recognized tribes, urban Indians and rural Indians) and provides for separate funding for each group.

NTCA fully supports the federal responsibility and continued funding for the health care of federally recognized tribal members wherever they may reside away from Indian country. Such funding must be adequate to meet need, but must not be taken from the amounts required to provide proper health care in Indian country itself.

Charges to Indian Individuals and Third Party Reimbursements

The Office of Management and Budget has recommended to the Department of Health and Human Services that IHS plan to supplement its funds by charging Indian individuals and actively collecting third party reimbursements (Medicaid/Medicare, federal employee, liability and other private health insurance). IHS plans to collect some \$67 million in FY'84 from third party sources. IHS does not have the staff or know-how to manage such collections, if they can indeed obtain them. Its authority to make these collections rests with P.L. 94-437, Title IV, the Indian Health Care Improvement Act, expiring at the end of FY'84.

NTCA endorses the reauthorization of P.L. 94-437 with its Title IV amended to assure that third party collections are retained by the collecting Indian health facility to supplement, not supplant needed health services.

Indian Health Manpower

NTCA strongly supports the reauthorization of P.L. 94-437, the Indian Health Care Improvement Act, Title I, and its 1980 amendments. We recommend the following changes to the Act: 1) expansion of Section 103 (preparatory and pre-graduate programs) to include scholarships in pre-nursing, pre-medical technology and pre-physical therapy; 2) limitation in Section 104 of health professional scholarships to Indian students only; and, 3) inclusion in the Section 105 extern program of Section 103 scholarship recipients.

It is also NTCA's position that the other federal programs which provide health professionals to IHS (Health Careers Opportunity Program and National Health Service Corp.) must maintain their current contributions to IHS and must not be phased down or redirect their funds to other areas. Otherwise, IHS and tribes will have virtually no health professional pool to draw from by the year 1987.

Senator ANDREWS. Dr. Marquart.

**STATEMENT OF DR. CLARK MARQUART, MEDICAL DIRECTOR,
INDIAN HEALTH MANAGEMENT, INC., ROSEBUD, S. DAK.**

Dr. MARQUART. Yes. Just a few comments. My name is Dr. Clark Marquart. I am a general practitioner and during the 9 years I have been in practice I have served native Americans in a variety of settings.

Following my internship, I began my medical career in the Rosebud hospital in Rosebud, S. Dak. as a volunteer employee of IHS. I remained approximately 1½ years, resigned from the Indian Health Service when I left Rosebud, frustrated, I must say, and have not worked directly for the Indian Health Service since, despite remaining in Indian health care.

I was next employed at the Seattle Indian Health Board as a practitioner, and subsequently by the Puyallup Tribe of Indians in Tacoma, Wash., in their tribally operated clinic.

I have been back working on the Rosebud Reservation for the past 2½ years as a practitioner and director of Indian Health Management, Inc., which is a nonprofit organization which supplements the Indian Health Service at Rosebud. I am currently a member of the National Health Service Corps assigned to this organization.

Senator ANDREWS. Are you a contract physician? Is your group contract physicians through the Rosebud Sioux or are you paid by the Indian Health Service?

Dr. MARQUART. I am paid specifically by the National Health Service Corps, assigned as a member of the Service Corps to the Indian organization, Indian Health Management, Inc. Likewise, some of your middle level practitioners are Corps members. That is, physician's assistants, one nurse midwife, and we have just been assigned a podiatrist who is a member of the National Corps.

Besides the corps salaries that have come to the organization in this management from the Federal Government we will have a grant that helps us sponsor and operate clinics in small towns on the reservation as well as to continue the mobile clinic efforts which were begun years earlier through the same organization. So I am currently in the National Health Service Corps.

In my capacity as medical director, we have had occasion to work extremely closely with the Indian Health Service in the same hospital I began my career in, as well as the tribe and the State in health related matters. Working as a physician in Indian health can be and has been for me, at times, extremely frustrating. The depth and the long term duration of problems, in the Aberdeen area particularly, appear worse than any other area of the Indian Health Service. There are, for example, tremendous problems: professional staff turnover, vacancies, inadequate and antiquated facilities, a dramatic level of morbidity and mortality compared to the rest of the Indian Health Service service population and gross underfunding for the task at hand. Each of these problems appears to magnify the other and complicates finding solutions.

At Rosebud the IHS hospital has stood half condemned since 1978 for safety reasons. We are still seeking the release of a fiscal year

1982 appropriation for planning and designing a new facility. This money has not yet been released for use.

In fact, there was a period in which the appropriation actually had to be salvaged from efforts to reprogram it for other purposes, specifically salary increases during the last fiscal year. The appropriations seem safe, but it is unreleased for use.

In 1981, more than 170 different doctors practiced within that one hospital in Rosebud, S. Dak. There was only one permanent staff member on the staff. This physician was a pediatrician. He happened to be a native American with heritage at Rosebud.

The doctor who was there when I got back 2½ years ago remains on the reservation. She is now working full time with our clinics and again I think this points out that there is some validity to the comments that were made earlier about training Indian people in health care.

While I have returned I have to say a great deal of the reason I came back was the perception of my needs there when I first left. I do not think you can count on a group of doctors like that to consistently staff that facility. History has shown it otherwise. With 170 different doctors rotating through the hospital at that point, a lot of them came through Project U.S.A. Some were temporarily assigned from elsewhere in the IHS. Most were staying a matter of 1 to 3 weeks, something on that order, literally no continuity of care. It is very easy to verify a great variation in quality of services of those 170-some-odd physicians who came through there.

We have had one doctor who did not turn out to be the person he said he was. He was using the name of a physician in New York who had been deceased for 3 years. We had one doctor come through there whose favorite way of treating a number of problems was the same method of treatment which makes no rational sense to anyone. Taking a handful of cotton, putting it in the belly button, and putting tape on top of that. Now out in my clinics I had patients come to me saying, "This is the way I was treated at the hospital by a certain doctor." I had gone to the hospital where I also have staff privileges, reviewed those patients' records and in fact that information is within the patients' charts. To a couple of the patients perhaps it did not matter so much. They had nonthreatening illnesses though they were sick.

The third patient and the one that prompted my looking into the situation was a gentleman who arrived at the hospital complaining that he felt he needed to be transfused with blood again. He thought his stomach was bleeding again. He had been throwing up blood. He was dizzy, complained that he thought he was going to pass out. The note in the hospital chart of this particular individual reads that this doctor examined him, attributed his dizziness to cervical neck muscle spasm for unexplained reasons, took a hunk of cotton, put it in his belly button, taped it, sent him home. By the time we were able to recover that patient for treatment the following day he was unable to sit up at home without passing out.

This was one physician at the facility. We knew there were better ones. We contacted one of the better physicians, told him the situation, got him to agree to admit the patient and transfuse him. The man is alive today.

But that is another example of what transient sort of medical help can really bring to the reservations. It brings distrust; it brings inadequate, uncontrolled quality medical care, and some sort of solution to these problems must be sought.

Senator ANDREWS. Who controls the quality or the standards of these physicians before they are inflicted on the members of the tribe?

Dr. MARQUART. Clearly it has been impossible for the local service unit or the area office to individually evaluate and dig into the job history and background and credentials of each and every doctor with that many physicians passing through one hospital.

IHS has a contract with Project USA to come up with a lot of these individuals, and now Project USA, I think, is overseen by—I am not sure of this, but my belief is it is one individual in Chicago by the name of John Nown. How many hundreds of doctors he processes, I am unaware. Whether his organization is really sizable enough to make these kinds of verifications, I am also unaware. All I can verify is the problem has been occurring and it must be taken seriously.

Some improvement in that point since 1981, the really low point in staffing the hospital, has now occurred in physician staffing. We now have just one Indian doctor who is the only permanent doctor there. There are four people on the staff but a variety is especially needed. Our own organization shares some of the staff with the hospital in terms of a midwife so that we now are capable of delivery again.

The temporary doctors who are being assigned, I think because in part of these problems that I have been naming to you, have been less and less from Project USA, more and more temporarily assigned from elsewhere within the Indian Health Service. That group of doctors coming from within the Indian Health Service to the reservation to fill in always seems to have a bit better background, a bit more assured competence than the sort of take a look and hire on fellows for a week or two. But it has been a significant problem. Sometimes when I went to the hospital to discuss these matters with the service unit director the problem had already been solved in that particular case because the doctor was already gone. Well, that one has gone now. We have a new batch this week.

Senator ANDREWS. Is Indian Health Management, Inc., solely on your own reservation?

Dr. MARQUART. Yes. We have a tribal charter as well as a State charter, but our designated service area is Todd County, which at this point in time represents the entire reservation.

Senator ANDREWS. And you are paid by IHS funds?

Dr. MARQUART. We have arrangements through memoranda of agreement with the Indian Health Service by which certain things that we have, and they need, are shared, and vice versa. The Indian Health Service provides us with medications and with a certain amount of supplies. We have taken a mobile clinic that they own but did not have staff to operate, and staffed it and gotten it functional.

A good deal of what we do is in concert with the Indian Health Service, but we do not receive any direct dollars from the Indian Health Service.

Senator ANDREWS. But when the patient, the tribal patient, comes into your facilities their charges, their billing is picked up by BIA funds or by—

Dr. MARQUART. Our facilities, which are purely outpatient facilities, have a sliding fee scale. By virtue of being a rural health-initiative clinic, we follow the Federal guidelines and we have a sliding fee scale. Eighty percent of our patients fall into the zero pay category and we do not seek reimbursement from those patients because the grant is designed to assist with their care.

Senator ANDREWS. So, your fund is by grants from outside the IHS or anything else.

Dr. MARQUART. Exactly right, or Indian Health. Exactly right.

Senator ANDREWS. The type of organization that you represent is set up as a charitable foundation or something.

Dr. MARQUART. It is indeed. It is a nonprofit foundation.

Senator ANDREWS. Is that the way quality health care delivery can be achieved on an Indian reservation?

Dr. MARQUART. Yes. We believe it can be.

Senator ANDREWS. At a reasonable cost, and what you are doing has the support of the tribal officials on that reservation.

Dr. MARQUART. It does. Our efforts have been supported by the tribe, the local Indian Health Service in particular, which has worked very closely with this, and also the Aberdeen area office which is aware of our approaches, newer approaches in some ways to care on the reservation, and the State itself which has from time to time had us handle certain portions of its grant funding, like maternal and child health, for instance.

Senator ANDREWS. What have they then done to move this working system to other reservations that have quite great needs?

Dr. MARQUART. What have we done as an organization?

Senator ANDREWS. No. Not you. The Indian Health Service and/or the BIA.

Dr. MARQUART. I am unaware that they have tried to establish similar things elsewhere. The impetus for establishing an organization did not originate with the Indian Health Service.

Senator ANDREWS. I suspected that from the pattern that I have seen established in the last 3 years, but I was just wondering whether when something occurs that they were not responsible for but which they ought to be able to realize is functioning quite well and serving a great need, what then is their response. Do they try to emulate that particular success story in other places or do they largely ignore it and cooperate with you because it takes care of a need that they then do not have to worry about—

Dr. MARQUART. I think, with all due respect, that question would be better directed to somebody within the Indian Health Service.

Senator ANDREWS. Oh, it will be.

Dr. MARQUART. To answer your question, though, I am unaware that they have tried to set up similar things elsewhere.

Actually we have picked up some things Indian Health Service was doing in the past that the legislation is no longer capable of, such as mobile services and field health clinics. They used to be operated on the reservation but inadequate funding and personnel do not seem to allow it anymore. The need is clearly still there given transportation problems and an inadequate hospital to serve the whole reservation in staffing and resources.

Senator ANDREWS. Thank you, very much.

Dr. MARQUART. Surely.

[The prepared statement follows. Testimony resumes on p. 175.]



Indian Health Mgt., Inc.
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(605) 747-2239

June 7, 1983

Patricia Zell
Senate Select Committee
on Indian Affairs
Dirksen Senate Office Building
Washington, D.C. 20510

Dear Patricia:

Here is the written testimony I promised to submit to the Select Committee. Enclosed also are more detailed comments on the Task Force report, which I thought the Committee or its staff might wish to review. These longer comments need not be made a part of the official record, however.

I have two brief requests:

1. I would appreciate either a quick note or a phone call indicating that my testimony has been received, and will be made a part of the official hearing record, and
2. Please add my name to the list of those desiring to receive a copy of the printed record once it becomes available from the Government Printing Office.

Thanks very much.

Sincerely,

Clark Marquart, M.D.
Medical Director

Enclosures

Testimony for the Field Hearings of the Senate Select Committee on Indian Affairs, Grand Forks, North Dakota, June 2, 1983.

Witness Background

My name is Dr. Clark Marquart, I'm a general practitioner, and have served Native Americans for the nine years of my practice in a variety of settings. I have worked for the Indian Health Service, an urban Indian Health Board, an urban clinic operated by a Tribe, and currently am a member of the National Health Service Corps assigned to Indian Health Management, Inc., (IHMI) on the Rosebud Sioux Reservation in South Dakota. This represents a return to the Rosebud Reservation, as my career began there as a volunteer employee with the IHS in 1974. I have served as both a practitioner and Medical Director of IHMI for the past two and a half years.

Indian Health Management, Inc., is a non-profit organization, with a nine year history of increasing involvement and responsibility in health care on the Rosebud Reservation. Chartered by the Rosebud Sioux Tribe and the State of South Dakota, IHMI was established to supplement the care delivered locally by the IHS, and to explore innovative approaches in health care delivery compatible with the severe problems facing the Rosebud Sioux people.

Current Problems

Working as a physician in Indian health can be, and has been for me at times, extremely frustrating. The depth and longterm duration of problems in the Aberdeen Area appear to be worse than in any other geographic region served by IHS. There are, for example, tremendous problems with professional staffing turnovers and vacancies, Service Unit Director turnovers and vacancies, inadequate and antiquated facilities, dramatic levels of morbidity and mortality, and gross underfunding for the task at hand. Each of these problems magnifies the others, and complicates the search for viable solutions.

At Rosebud, the IHS hospital has stood half condemned since 1978, for safety reasons and code violations. We are still seeking the release of an FY 82 appropriation to Plan and Design the replacement facility. In 1981, more than 170 different doctors rotated through the hospital, providing highly variable quality and no continuity of care. The Rosebud Sioux Tribe has had a significantly positive population growth trend, at the same time that availability of a number of critical health services has seriously declined.

There has been no surgery at the Rosebud Hospital since 1978. Because of equipment and temporary lab staffing problems, the IHS hospital had no blood for transfusion recently for a period of a year and a half. When I returned to Rosebud in January, 1981, the hospital had no physicians on the staff capable of routine obstetrical delivery, with the exception of its only permanent staff member, Dr. Lucy Reifel, a pediatrician.

Contract Care Funds

Vigorous local efforts have since corrected the problem of no blood, have assured routine local obstetrical delivery capability, and have provided

the hospital with a more permanent and better qualified staff. Despite these increases in local capability, the Rosebud Service Unit's budget for Contract Care has already been exhausted for FY 83, earlier in the fiscal year than ever before. It has been running out every year, of course, though authorizations have been limited to critical life or limb situations only.

This year, the funds were exhausted in early May, leaving the Service Unit to face some five months of being unable to authorize payment for life or death Contract Care emergencies. Rapid City Regional Hospital has already notified the Rosebud Service Unit in writing that it will not provide any services to Rosebud patients without a signed authorization, which cannot be given. A number of outside hospitals are loudly complaining of unpaid IHS bills, or unacceptably delayed payment. The IHS, on the other hand, claims that much of this care, though clearly needed, had not been prior authorized by them. Instead of working cooperatively to maximize critical medical care to Indians, in South Dakota the private medical sector and the IHS are too often at financial odds with each other, with the underserved Indian patient trapped in the middle.

This is not meant to imply that either sector may be fairly blamed for the denial of care to Indians, or the lack of comprehensive health services so badly needed in the Aberdeen Area. If Native Americans in the Aberdeen Area had adequate availability of medical care, the financial feud which has been developing over the years between the private sector and the IHS locally would have never begun or never developed to the unfortunate point it is at today.

Nor is mismanagement at the local Service Unit level responsible for running out of Contract Care funds earlier each year. Nonetheless, every year someone, usually a higher level Contract Care Officer, tries to place the blame for grossly insufficient Contract Care funds on local mismanagement. Every year they are wrong, and this type of behavior is greatly resented by dedicated staff at the local Service Unit level who have had it up to here with having to deny care right and left anyway by that point in the year.

What then are the real factors precipitating the record shortfall at Rosebud? A number are readily identifiable:

- 1) The Aberdeen Area as a whole is greatly underfunded with respect to even Priority I Contract Health Service needs. The equity with which the IHS Headquarters allocates these funds between Area Offices is highly questionable, especially given the fact that for more than two years they have refused to divulge to the Aberdeen Area Office the methodology used to determine the Area's Contract Care budget. Apparently only Congressional inquiry would bring such information to the light of day. Without it, there is not a shred of evidence that their methodology is rational or responsible. In all likelihood, it represents another example of the longstanding geographical inequities in the IHS allocation process, which Congress is already familiar with from GAO studies, etc.

- 2) The Aberdeen Area of the IHS has fewer direct services available than other IHS Areas, including no IHS referral hospital and a lack of comprehensive services at the Reservation hospitals, both requiring increased outside referrals.

3) The Rosebud Service Unit's Contract Care budget has not been increased for three years, despite rapidly rising private sector care costs and increasing population.

4) The lack of surgery at Rosebud since 1978 has certainly played a role in both increasing the need for Priority I Contract Care authorizations and increasing the denials of all surgery that is not deemed a critical emergency, threatening life or limb. The only Service Unit in South Dakota still providing any surgery locally is Pine Ridge. Though this Service Unit is near ours, surgery provided there is seldom available to the Rosebud Sioux, as local demands keep them sufficiently busy. As an example, the Rosebud Service Unit was able to get the Pine Ridge Service Unit to accept only two surgical patients for the current month (June), their operative schedule already being full with their own patients.

5) There have been unfortunate increases in serious accidental injuries throughout the Aberdeen Area, including injuries purposely inflicted by others, a fact that the Tribes themselves must also take note of and deal with. Such injuries are commonly expensive to treat, and the financial toll to Contract Care budgets throughout the Aberdeen Area has been devastating. More often than not, alcohol and alcoholism are directly involved in such injuries.

6) There is no mechanism by which the local Service Unit can share the financial liability of catastrophic illness when it occurs from time to time. Such risk sharing is commonplace with private insurance, prepaid health care plans, etc. The total IHS service population is certainly large enough for such a mechanism to work, but none exists.

Poverty and Health Status

Whether intimately related or entirely coincidental, financial poverty and impoverished health go hand in hand on the Rosebud Reservation and on other Reservations within the Aberdeen Area. Four of the ten poorest counties in the whole nation (as measured by per capital income) are Indian areas in South Dakota.

Of all eleven IHS Area and Program Offices, the Aberdeen Area has the highest general mortality rate, the highest infant mortality rate, the highest rate of accidental deaths, and the highest birth rate. In fact, Aberdeen Area death rates for all of the following causes of death greatly exceed the averages for the entire IHS patient population as a whole: heart disease, alcoholism and cirrhosis, influenza and pneumonia, diabetes mellitus, suicides, and homicides.

Practically all forms of infectious disease are greatly increased in incidence in the Aberdeen Area, including a number of less common and more serious illnesses, such as tuberculosis, salmonellosis, rheumatic fever, and hepatitis. The incidence of tuberculosis has been higher on the Rosebud Reservation and in one other South Dakota county, than anywhere else in the United States. With this as the starting point, we have just learned that the Aberdeen Area has demonstrated a recent, alarming increase in active TB cases, a sad commentary on the adequacy of public health measures within the Area, and evidence to support the contention that a lower level of IHS activity threatens to undo improvements attributable to 30 years of IHS effort.

The Aberdeen Area of the IHS represents a pocket of health poverty within the United States, and within the Indian sector as well. Every health statistic I am aware of verifies this.

Progress and Hopeful Signs

Given the level of problems at Rosebud and in the Aberdeen Area, one might wonder if hope for improvement is realistic. I think there are a number of reasons for optimism in this regard, many of recent origin:

- 1) As noted above, the Rosebud Hospital now has blood, a qualified laboratory supervisor, a more stable medical staff, and local routine obstetrical delivery capability, all lacking in 1981, which seemed in many ways to represent the lowest level of local service availability - hopefully the bottom of a long decline in services, with improvement now beginning.
- 2) Plans are underway to reopen the surgical suite at Rosebud within a month or two from now, initially for limited ENT, OB/GYN, and podiatric (foot) surgery. This follows at least two years of local and Area Office effort to reestablish surgery at the Rosebud Service Unit.
- 3) There are new ideas emerging at all levels, and there appears to be increasing recognition that the severe problems of the Aberdeen Area must be addressed by new approaches and more equitable funding.
- 4) The IHS Task Force on Contract Care recommendations have the potential of relieving chronic inequities in funding throughout the IHS, a step the IHS has not been willing to take for years, though the adverse effects of the now traditional inequities have been increasingly evident.
- 5) The past Secretary of Health for the State of South Dakota, Dick Blair, is now working full time as a facilitator between parties interested in improving health care for Indians in this area, including the IHS, the State, the corporate medicine sector, the academic medicine sector, Indian Health Management, Inc., and others. Meetings between these various parties have been progressing well, and have the potential for outlining new solutions to a number of chronic problems in local delivery of Indian health care.
- 6) The new Secretary of Health for South Dakota, Lorry Massa, has likewise indicated his support for cooperative addressing of these problems.
- 7) Dr. Rhoades, of the IHS, and his predecessor, Dr. Emery Johnson, both have indicated an understanding of the importance of locally identified potential solutions. Dr. Johnson went as far as to say that most significant improvements will ultimately be dependant upon bold, local efforts. He recognized such local efforts as

agonizing and demanding, difficult to categorize or standardize, but at the same time, having the greatest potential to work. Such attitudes are a prerequisite to a fair chance being given by the bureaucracy to new, local solutions, which seldom fit neatly into the standard current practices, and force administrative tolerance of a variety of "bottom up" exceptions to "top down" national IHS policy and mode of operation.

- 8) Indian Health Management, Inc. provides a strong example of a local organization devoted to searching for improvements and new, local solutions. It now has nearly a 10 year history of identifying and implementing innovative approaches to health care delivery at Rosebud. We operate two full time community clinics in population centers distant from the hospital, as well as mobile clinic services to a variety of outlying communities. We have nurtured and seen blossom the increasing cooperation and coordination between IHMI and the local IHS Service Unit, to the point of sharing resources, personnel, and further ideas. The same is beginning to occur with the State of South Dakota. Because of infant mortality two and a half times the national average, we have markedly increased prenatal care on the Reservation, including mobile services, and devote more of our midwife's time to the IHS hospital than to our own clinics. IHMI's Better Health Program, recently established, represents a marked increase in disease prevention and health promotion effort on the Reservation, one key to future health status improvement. We have been able to assist the Rosebud Sioux Tribe in health related matters, and have assisted both the local Service Unit and Area Office in physician recruitment. Dr. Johnson was correct; the efforts have been agonizing, demanding, and I would add, frustrating. But the ideas are still coming, the enthusiasm is still there, and we continue to make progress in a difficult situation.

Elevation of the Office of IHS Director

I strongly favor this idea being promoted by the Indian Health Service and the Tribes. In our own experience with the new Rosebud Hospital funding, the IHS processing of the Program Information Document and the Tribes PL 93-638 contract proposal for the Plan and Design took an inordinately long time. Since Dr. Rhoades final approval, however, higher levels than the IHS have held up both matters, with still no final HHS action on either. The contract proposal has been held by them for some 5 months now, and the PID for over 12 months. Thus, use of the FY 82 Plan and Design appropriation has still not begun. Efforts to reprogram the appropriation last year took place without Dr. Rhoades or the IHS's involvement.

I'm sure examples abound which demonstrate the Office of the Director should be strengthened.

Reauthorization of the Indian Health Care Improvement Act

Clearly, both the Tribes and the IHS strongly support reauthorization of this act. The emphasis should perhaps be on changes needed in the language or manner in which the intent is implemented.

Delays in construction of needed health facilities have been significant. The Aberdeen Area has had no new construction take place for nearly 25 years, and facilities have continued to decline. The Aberdeen Area badly needs equitable facilities, just as it needs equitable funding.

The Inmed Program holds the best promise of stabilizing IHS professional staffing with Indian practitioners, and deserves vigorous support.

There have been major problems with Medicare/Medicaid reimbursements, particularly in regard to the fact that the amounts available to the Service Unit for local use bear little relationship to the amount collected by them. At the Rosebud Hospital, for instance, major repair needs have been repeatedly postponed because, after all, a brand new Rosebud Hospital has been just around the corner for the past 10 years. Much of the Medicare/Medicaid collections at Rosebud have been used elsewhere in the IHS, and the same is true for the Aberdeen Area as a whole.

Perhaps the most critical change which could be made in reauthorizing this act would be to add language specifically prohibiting the use of IHS Medicare/Medicaid reimbursements as an offset to the IHS budget, and clearly stating that the intent of Congress is that these collections will be made available to supplement the efforts of the IHS, not vice-versa.

Having worked in urban Indian health care situations previously, it is my impression that such programs are just as cost effective as other alternatives, and far more culturally sensitive. I see no advantage to the Federal government in shifting urban Indian health care responsibility away from the IHS and into other Federally supported programs, unless the hidden intent is to disenfranchise all Indian families who have had to move to the urban environment to seek gainful employment, etc. The issue is clearly one of trust and treaty responsibility.

Community Health Representative Program

The sentiment on Reservations is strongly in favor of continuing the CHR program, for both health related and employment related reasons.

I too favor retaining the program, but feel that it should be revitalized and redirected by appropriate means. For example, disease prevention and health promotion activities should be a prominent part of all CHR programs, not in philosophy alone, but in concrete, realistic actions. To achieve this end, some changes in personnel and personnel selection may be necessary. CHR's should be hired on the basis of their learning and teaching abilities, and their enthusiasm for being an active health promoter in the communities. Tribes should avoid considering selections on the basis of politics, family relationships, or longevity as a CHR (unless the job record verifies full capability). Some CHR Programs are beginning to make this transition on their own.

IHS Task Force Report on Contract Care

The Task Force report presents long needed recommendations designed to reduce unmet health care needs and inequities within the IHS system. There

is significant danger, however, that the validity of the actual recommendations will be overshadowed by the attempts to lower the expectations and responsibility of the IHS.

When the 24 specific recommendations are examined in only their summary form, I have major objections to only one: changing terminology in order to promote a lesser role for the IHS.

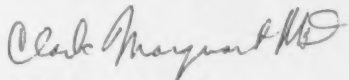
The Task Force report has been difficult to review because it seems to reflect two greatly different attitudes within the same document. The first is entirely appropriate, long overdue, and clearly beneficial to the IHS service population. This attitude has resulted in concrete recommendations for increasing the total resources available for clinical services to eligible Indian people, and for rationally distributing IHS resources. All of the 24 recommendations are compatible with this attitude other than the suggestion that terminology be changed in the interest of reflecting a lower level of IHS.

The second attitude, however, is clearly detrimental to the IHS service population, that of forced reduction in IHS services and responsibility. This attitude is only expressed in the broader explanations for the actual recommendations, that is, in the main text. The appearance is that of excellent effort to improve the IHS, while signaling a serious intent to lower its level of services.

I would strongly urge that all of the Task Force report content that relates to a lower level of IHS responsibility, acting only as a supplement to other resources, etc., be discarded entirely. This is also the only area in which the Task Force appears to have overstepped its initial charge from Dr. Rhoades for policy recommendations "that would not adversely affect the relationship of IHS to its service population."

In my opinion, the rest of the report, including most of the actual recommendations, shows considerable promise. The administrative improvements, limiting of certain tertiary services, increased third party resources available, and so forth, should increase IHS's abilities to serve its patient population. I see no reason for the emphasis on declining IHS responsibility, and feel the Task Force report was unnecessarily clouded by such discussion.

Finally, I would like to thank Senator Andrews for requesting my testimony as a practitioner involved in Indian health, and hope my comments are useful to the Select Committee in their fact finding mission.



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Comments on the Report of the IHS Director's Task Force on Contract Health Services, February, 1983.

The Task Force report was received at Rosebud on March 30. Though time to digest the contents and prepare these comments have been minimal, it is hoped they will be of value, nonetheless.

The problems examined by the Task Force are indeed critically important. Many others agree that fundamental changes are required in IHS policy to equalize and maximize available services, while continuing to strive for improved health status.

While the Task Force was noted to be unanimous in its recommendations, constituent responses are not likely to be. We strongly favor many of the recommendations made, while at the same time have serious reservations about others. For example, solutions to the long-standing service availability inequities have been hoped for for years. The Task Force has outlined a workable plan of resource allocation designed to finally have major impact on this clearly identified problem. Yet, on the other hand, the report has a definite flavor of a decreasing responsibility by IHS for Indian health, and phrases like "Last Health Resource for Indians" will reinforce the view in some people's minds. So will denying authorization to transfer a newborn for intensive care.

Terminology

At first glance, the change in terminology suggested appears to be of less significance among the Task Force recommendations. Viewed in light of the rest of the report, however, it seems to reflect a recommended decline in the level of IHS responsibility in Indian health. This decline would bring the IHS level of responsibility closer to its limited resources, and presumably add a sense of administrative balance.

Despite numerous improvements attributable to the IHS, the health status of Indians still commonly lags far behind that enjoyed by other Americans. Even if the IHS does not have sufficient clinical resources and contract care funds, it must assume the leadership in outlining the need and searching for solutions. Rather than viewing IHS's role as "supplementing and complementing other public and private resources available to the (IHS) patient," it should be seen as sole provider for a large number of its service population, while seeking all forms of available assistance in its efforts. Once assistance is located, the IHS should view it as a supplemental resource, not the responsible party from now on. Likewise, when no resource can be identified, it is far better for the IHS to be in a position to define the deficiency, be willing to portray it, even dramatize it if necessary. The overall underfunding of the IHS cannot improve without the portrayal of documented need.

The Task Force obviously did pursue additional available resources for the overall task of providing care needed by Indians. We do not agree, however, that the IHS should lower its level of responsibility or declare itself supplementary to a number of other public or private resources, precisely because of "the influence of language on thinking and behavior," referred to in the report. The resultant IHS attitude could run contrary to the best interest of IHS beneficiaries as well as adversely affect the relationship of IHS to its service population. Preferential utilization of available third party resources does not, by itself, require this terminology and attitude change.

Programmatic Reorientation

The recommendation to reorient management policy for IHS clinical services to assure predetermined priorities of medical services is necessary to carry out the general Task Force plan. However, the concerns described immediately above also apply here. Predetermined priorities for medical services must, of course, be compatible with the total resources available. This should not in any way diminish IHS recognition and documentation of the large body of unmet needs for which current IHS funding and third party supplementation cannot provide. Reminding Congress periodically that the IHS is greatly underfunded for the task at hand, is far more preferable than reducing the level of IHS responsibility to match current underfunding, and considering the job done and the IHS sufficiently funded for its responsibilities. Such an attitude would hold little promise of every achieving sufficient medical services for Indians or comparable health status with other Americans.

Eligibility for IHS Services

We agree with the Task Force that clear and objective eligibility criteria should be established for IHS provided services, and that such criteria should apply to both direct and contract health services in an identical fashion.

We likewise agree that blood quantum should, in general, not be utilized in determining eligibility for IHS services because of the reasons stated by the Task Force. An argument could be entertained, however, for say a one eighth blood eligibility limit for non-Reservation based Tribes, the idea being that members of Reservation based Tribes are typically more closely economically tied, and much further removed from non-IHS sources of care. Service areas such as Oklahoma would be affected by such a rule, as would urban Indians. Any such consideration would have to be preceded by IHS assurances that it has no intent to establish blood quantum eligibility for Reservation based Tribes, particularly in light of the fact that many people are becoming convinced that the IHS is purposefully and methodically reducing its level of responsibility in stepwise fashion.

The three eligibility factors recommended by the Task Force (membership in a Federally recognized Tribe, residence within a clearly defined IHS service area, and formal enrollment) appear to be satisfactory.

Mention was made in this section of the Task Force report that the IHS "could treat non-Indians who are able to pay for service as long as provision of service to non-Indians did not reduce care to eligible Indian patients." While legal clarification or statutory authority might be needed to embark on such arrangements, it is clear that some underutilized IHS facilities as well as non-Indian patients isolated from a source of care could benefit a great deal. Assuring no reduction in care to eligible Indian patients could present difficulties in busier settings, however. A good starting place might be to allow formerly eligible patients, (such as spouses, non-Indian children in the household, etc.) purchase care from the IHS, as many have had established IHS charts for years anyway.

A brief explanation might be in order in terms of how the service population would be determined at an IHS hospital providing referral services (such as OB surgery) to other Service Delivery Areas. Those of us in the Aberdeen Area lack familiarity with the usual mechanisms of an IHS referral hospital, having none. If a patient is referred from one Service Delivery Area to another for treatment services located there, would he be considered a member of both service populations for purposes of resource allocation?

Clinical Priorities (Service Priorities)

The Task Force comments and recommendations related to clinical priorities present major problems and offer little improvement to the current situation. There is nothing wrong with the basic goals of defining priority services to best utilize the insufficient IHS Clinical Services budget, and assuring comparable availability to all IHS eligibles could be a major victory over longstanding inequities. The tone of the discussion, however, is often that of defining what services the IHS will not bear any financial responsibility for, including neonatal intensive care, if the newborn must be transferred to another hospital to receive it.

The Task Force recommends three categories of services be given priority. If these categories alone came to be viewed as the benefit package assured to all IHS eligible patients, the IHS might be soon reduced to and held at funding levels compatible with limited preventive, basic primary care, and emergency stabilization only. Eventually one might expect little or no interest in all other areas of care, having no financial involvement. Third parties can indeed provide some needed care above these levels, but an increase in already unacceptable unmet health care needs would inevitably accompany any significant curtailment in IHS services.

Category A,B, and C, roughly reflect all that is currently available through IHS for patients here at Rosebud. Other than ENT surgery available to Rosebud patients elsewhere, most of the list considered as "discretionary" services under Category C are not routinely available to Rosebud patients, and therein lies a significant body of unmet needs. With this important list of services left as "discretionary," it is likely that inequities currently existing will remain in place.

The same is true for a number of specialized procedures included in Category D, where the "initial hospital" situation applies. For patients with limited local IHS hospital services available, the IHS will not pay for even short term newborn intensive care elsewhere, or a number of other important services. Indian patients without third party resources will be effectively denied CAT scan diagnostic procedures altogether. For many patients, IHS denial of payment for a needed service does mean the service will be unavailable to the patient.

As with much of the Task Force report, this section presents difficulty in separating valid and much needed suggestions from the apparent effort to promote in the IHS a new philosophy of diminishing services and responsibility.

We would suggest that the prioritizing of clinical services is essential, and that the intent to assure the same level of care is available to all IHS eligibles is admirable and long overdue. While mentioned, greater emphasis should be placed on the fact that the IHS is in no way restricted to providing only the basic prioritized services, just that those services will be assured first to all enrolled patients before lower priority care is authorized for anyone with clinical services funds. Care must be taken to assure that services available beyond the basic service priorities receive equitable distribution throughout the IHS service population. The attitude must be avoided that those already having availability of additional services may keep them, but those requiring the establishing of such services must do without.

Lastly, the resource allocation formulas address only the distribution of funds sufficient to satisfy the basic service priorities. As noted above, equity must also be assured for the balance of available IHS services.

Resource Allocation

We vigorously support the Task Force general recommendations concerning resource allocations, and feel that such measures would have been appropriate years ago. Minimizing the "program continuity" aspect of the IHS allocation methods is a prerequisite to ever achieving equity within the IHS. Likewise, combining the direct care and contract care IHS budgets into a single clinical services budget would greatly facilitate equitable distribution of resources. IHS health service delivery areas will still vary in terms of what direct services are available locally, making separate assessment of equitable direct and contract care needs difficult.

It is our feeling that the Task Force recommendations would fully satisfy Court and Congressional directions to establish a rational basis for the distribution of IHS's resources. We fully understand and hope others will, that without significant increases in available resources, the only way to rid the IHS of gross inequities is to supplement those with fewest available services, while restricting those with higher levels of available services. The IHS has been reluctant to do this in the past. Yet over the years, no suitable alternative approach has been found, and in all likelihood none exists.

The Task Force has indicated that the resource allocation formulae presented need refinement for details, but reflect the concepts envisioned. Given that the formulae are not yet fully developed, we find little fault with them. Very brief mention was made that ultimately, the formulae should contain a number of factors which affect per capita costs, such as unique geographical, economic, and health status factors. Such flexibility is essential if the formulae use is to be maximally "rational."

Consideration might also be given to whether or not a Service Area might be inadvertently penalized in terms of resources for superior management resulting in lower than expected user per capita costs. If sound management can be identified as responsible for the savings, the Service Area should be clearly rewarded by some mechanism, and reduction of their allocation should be avoided.

From time to time, various IHS Service Units have faced catastrophic professional staff shortages, temporary closure, or other such factors dealing a significant blow to actual utilization rates. While we realize that a perfectly standard formula is simplest for administrators to use, utilization rates clearly affected by factors such as these are grossly inaccurate, and deserve modification prior to use in allocation formulae.

Service Delivery Areas

From the discussion in the report it is unclear whether or not patients of certain urban Indian health care programs would be eligible for IHS enrollment. The on or near a Reservation criteria would appear to exclude them, unless redesignation of HSDA's through consultation with the Tribal group(s) affected can be accomplished in this setting. The Task Force might have stated, for purposes of clarification of the actual or potential IHS service population, the extent to which HSDA redesignation can normally be accomplished, and on what basis.

Procurement Policy

No new recommendations, already implemented and continuing.

Payment Policy

We feel the recommendation to reimburse contracting hospitals and practitioners at rates computed according to the Medicare methodology is an excellent way to realize increased available services for the IHS service population.

Last Payer Status

Again the Task Force report bears indications of emphasis on reduced IHS responsibility. At the same time, the recommendations made can be seen to have the effect of increasing the total resources available for the care of Indians, so long as the third party resources are not viewed as justification for reducing the IHS budget.

There is significant, albeit hidden, danger to the health care for IHS eligible persons if third party resources are viewed as a substitute rather than a supplement to IHS resources. Apart from the accessibility and acceptability problems of increasingly off Reservation non-IHS care, Indian people face, if they are not already experiencing other major side effects from increasing use or forced use of third party resources located outside the IHS facilities.

One such effect is that IHS directly provided services, those located where the patients are, would become more severely limited in scope and availability. With declining IHS direct services, Indian people without third party resources would be expected to find more and more services unavailable to them.

As the scope of IHS direct services declines at various sites, IHS hospitals might become increasingly difficult to staff with professionals, who at times exhibit a "critical mass" phenomena. Insufficient colleague support and resource needs to perform to the level of their skills are significant problems in recruitment and retention. From personal experience at Rosebud we know it is difficult to retain well trained physicians who lack some of the tools of their trade, who are reduced to immunizing, stabilizing, and referring, whose hospital lacks routine services, and whose patients are often dead-ended in care because of IHS inability to pay and no one else with responsibility in the matter.

These appear to us to be good reasons for continued recognition of the overall underfunding of the IHS, while viewing third party resources as supplemental contributors to meeting the overall IHS service population need. We do not disagree with the IHS retaining its last payer status policy, so long as the third party resources gained are added to the IHS effort, without diminishing IHS direct resources or responsibility. The opposite approach shifting Federal health care dollars from the IHS to other Federally sponsored programs (to the extent that Indian people are eligible for them), dangerously threatens appropriate levels of IHS direct care where it is most crucial, on Reservations or in other isolated living situations. Much of the worst health in the United States remains among the various Tribes. It is vital to locally address both health care needs and health status problems, which only the Tribes and IHS can do. Greater IHS resources are called for, rather than substitution of responsibility.

On the other hand, we fully support the collecting by IHS of all third party resources which they may retain for further IHS use. Thus far, such Medicare/Medicaid collections have undoubtedly been helpful, but the return to the local Service Units has seldom correlated with the level collected by them. Additionally, the distribution to the Area Offices has demonstrated the now traditional IHS inequities, and we urge application of the rational methods under discussion to correct this problem also.

In terms of State resources available to the IHS service population, there tends to be a state by state variation in attitudes and willingness to make various State services available on Reservations, even when it is designated Federal funds to the States that make such services possible.

We do not favor the billing of Indian patients for IHS services rendered, and feel few Tribes will either.

Fiscal Agent

We agree that a Fiscal Agent might improve IHS collections and payment problems. We support the recommendation, so long as the cost-efficiency study and field testing suggested by the Task Force demonstrate promise.

Social Security Numbers

We do not agree that a social security number should be required for IHS enrollment. The reasons offered by the Task Force appear insufficient. There seem to be good reasons to collect social security numbers at registration if the eligible patient has one already, but no reason to force those who don't to get one. Such a measure would only unnecessarily increase Federal expense in the IHS enrollment process.

Medicaid Enrollment Information

Cooperation for such information does need to be sought.

Emergency Contract Services

We do not object to the recommendation for a shorter notification period, so long as vendors are assured of a reliable IHS mechanism to receive the notification.

Systems and Information Management

We concur with the importance and value to the IHS of such systems.

Legislation

We agree with seeking legislation designed to permit IHS to collect and retain third party resources, as this ability can only increase IHS service capability.

The Task Force has commented, as the IHS has previously, that earmarking of funds in Congressional appropriations for specific geographic areas and service populations over the years may have contributed to certain inequities in funding for health services among the Tribes. This is indeed likely. However, one must also grant the possibility that some such Congressional actions may have alleviated certain inequities the IHS was not correcting itself.

Congressional action enabling special initiatives, reorganization plans and the like, may well be needed from time to time to properly address severe problems in certain geographical areas served by the IHS. Such assistance should not be viewed by IHS as interference from Congress with its usual allocation processes or standard modes of operation, particularly if severe inequities can be reduced by the Congressional action.

Summary

The Task Force report presents long needed recommendations designed to reduce unmet health care needs and inequities within the IHS system. There is significant danger, however, that the validity of the actual recommendations will be overshadowed by the attempts to lower the expectations and responsibility of the IHS.

When the 24 specific recommendations by the Task Force are examined in only their summary form, we find just two that we significantly disagree with: requiring every IHS enrollee to apply for a social security number, and changing terminology in order to promote a lesser role for the IHS.

The Task Force report has been difficult to review because it seems to reflect two greatly different attitudes. The first is entirely appropriate, long overdue and clearly beneficial to the IHS service population. This attitude has resulted in concrete recommendations for increasing the total resources available for clinical services to eligible Indian people, and for rationally distributing specifically IHS resources. All of the 24 recommendations are compatible with this attitude other than the suggestion that terminology be changed (in the interest of reflecting a lower level of IHS responsibility).

The second attitude, however, is clearly detrimental to the IHS service population, that of forced reduction in IHS services and responsibility. This attitude is only expressed in the broader explanations for the actual recommendations, and one must wonder if the Task Force was as unanimous about the flavor of discussion as they were about the specific recommendations. If so, the appearance is that of excellent effort to improve the IHS, while signaling a serious intent to dismantle it.

We strongly urge that all of the Task Force report content that relates to a lower level of IHS responsibility, acting only as a supplement to other resources, etc., be discarded entirely. This is also the only area in which the Task Force seems to have overstepped its initial charge from Dr. Rhoades for policy recommendations "that would not adversely affect the relationship of IHS to its service population."

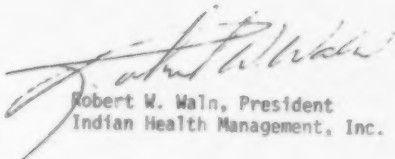
It is our opinion that the rest of the report, including most of the actual recommendations, shows considerable promise. The administrative improvements, limiting of certain tertiary services, increased third party resources available, and so forth, should increase IHS's abilities to serve its patient

population. We see no reason for the emphasis on declining IHS responsibility, and feel the Task Force report was unnecessarily clouded by such discussion.

These comments were prepared by Clark Marquart, M.D., Medical Director of Indian Health Management, Inc., at the request and with the concurrence of Robert (Sonny) Waln, President of Indian Health Management, Inc. For questions or responses to these comments, feel free to contact either of us. Address: Indian Health Management, Inc., Box 56, Rosebud, SD. 57570. Phone: (605) 747-2239.



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Indian Health Management, Inc.



Robert W. Waln, President
Indian Health Management, Inc.

Senator ANDREWS. Arta, I understand you are the president of the Tribal Health Authority at the Oglala Sioux Tribe.

**STATEMENT OF ARTA CARLOW, PRESIDENT, OGLALA SIOUX
TRIBAL HEALTH AUTHORITY, PINE RIDGE, S. DAK.**

Mrs. CARLOW. Yes, I am.

Senator ANDREWS. And your husband is with you?

Mrs. CARLOW. Yes, he is.

Senator ANDREWS. What do you do in your position as president of Tribal Health Authority?

Mrs. CARLOW. Oh, we work with the Public Health and with the tribe to meet the needs of our health care.

Senator ANDREWS. Are you responsible for the health care delivery system on your reservation?

Mrs. CARLOW. Yes.

Senator ANDREWS. How does it function, through the Indian Health Service or through funds that you get?

Mrs. CARLOW. We do not have any funds. We hold our meetings and do all our work free. We do not get any kind of stipends or anything. We have no money for that. But we do hold our meetings the first Friday of every month to try to take care of the needs that come up.

Senator ANDREWS. How many physicians do you have on your reservation?

Mrs. CARLOW. We have nine districts on our reservation and we have one board member from each district.

Senator ANDREWS. How many doctors do you have?

Mrs. CARLOW. At Pine Ridge we have seven doctors.

Senator ANDREWS. And they function with you?

Mrs. CARLOW. Yes.

Senator ANDREWS. Are you the interface between the doctors and the tribal members?

Mrs. CARLOW. Yes.

Senator ANDREWS. Do you encourage your tribal members to come in for preventive consultations with the doctors?

Mrs. CARLOW. Oh, yes. We have had to educate our people to come to our hospital. Now that we have most of them coming, we do not have enough money to take care of all the needs.

Senator ANDREWS. Even though you are saving money on individual visits by catching them early rather than late.

Mrs. CARLOW. Yes.

Senator ANDREWS. What is the outstanding feature of your system that you would like to share with other tribes?

Mrs. CARLOW. It seems like most of us have about the same thing going.

Senator ANDREWS. You have the problem of too few doctors and too far to go to get medical treatment?

Mrs. CARLOW. Yes. Like on our reservation—well, we are the second largest reservation next to the Navajo and our reservation is 120 miles long, 65 miles wide and we have only two ambulances on our reservation, two broken down ambulances. That is what we have to serve the people.

Senator ANDREWS. Well, I want to thank you for an excellent statement, Arta. It will be of great help to us.

Mrs. CARLOW. There are some other things that we do need for our people and that would be a dental program for adults and for glasses for our people. Those are some of the things that we do need and the cutbacks have affected our people so that we cannot get the care that we really need.

Senator ANDREWS. What percentage cut have you seen in health care delivery systems, dollarwise, on your reservation in the last 2 years? Has it been cut by one-third? Has it been cut by one-fourth?

Mrs. CARLOW. I do not know just exactly how much it has been cut, but we can tell the difference because we have patients that need to have surgery that have to wait until they get money for these things.

Mrs. CARLOW. What we would like is to have your help in getting our hospital into the 1984 budget and not the 1985 budget, so we could kind of hurry things along.

Senator ANDREWS. The construction of a new hospital?

Mrs. CARLOW. Yes.

Senator ANDREWS. We are fully aware of that and we will do what we can.

Mrs. CARLOW. And I think we should get that in the 1984 budget.

Senator ANDREWS. We have that in your statement?

Mrs. CARLOW. We do need the CHR program real bad.

Senator ANDREWS. Thank you. That is what we are hearing from most everybody.

Mrs. CARLOW. And, we support the INMED program that helps our students to get interested in medicine.

Senator ANDREWS. Well, you certainly have an outstanding young representative from your tribe. Thank you for appearing here today.

Mrs. CARLOW. And thank you for listening to me.

Senator ANDREWS. That is my job. It is good to have you here.

[The prepared statement follows:]

PREPARED STATEMENT OF ARTA CARLOW, PRESIDENT, OGLALA SIOUX TRIBAL HEALTH AUTHORITY, PINE RIDGE, S. DAK.

Mr. Chairman, Honorable members of the committee, Ladies and Gentlemen: My name is Arta Carlow and I am here today to speak to you on the severe health needs of the great Oglala Sioux Tribe, who live on the Pine Ridge Indian Reservation, a sovereign nation, located in the southwestern part of the state of South Dakota and ninety (90) miles from the Shrine of Democracy, Mt. Rushmore.

Mr. Chairman, to better acquaint you with our reservation and the proud and noble Indian people who call this land "home" we have by population over 20,000 enrolled members and of this figure 15,400 live in fifty-two (52) communities on the reservation. The Pine Ridge reservation covers an area of one-hundred and twenty (120) miles long and sixty (60) miles wide. The land is semi-arid consisting of rolling hills, prairies, and bad lands, suitable for grazing and temperature range from an extreme of -30 degrees below zero to a high of 115 degrees fahrenheit.

The economy of the reservation shows the average income of families on the reservation to be approximately \$3,920 per year or \$614 per capita per year. Depending on the definition the unemployment level of the community can be interpreted as being from 85 percent to 95 percent. A recent household survey shows that about 60 percent of the people still live in substandard housing. The average is three (3) rooms per house and occupancy is an average of six (6) individuals per housing unit. Running water is not available in most rural homes. Sewage disposal is usually a septic tank, however, there are still a large number

of outdoor facilities on the reservation that create health problems. Less than 10 percent of the homes have telephones. Public transportation is non-existent and less than 10 percent of the population owns or have access to an automobile. This creates problems of Indian people even getting to health care. There is one weekly newspaper that serves the reservation.

The Oglala Sioux Tribal Government consists of twenty-seven (27) members elected from nine (9) different districts, a tribal president, vice-president, treasurer, secretary and fifth member. The Oglala Sioux Tribal Health Board a nine (9) member board, is the official liaison group that works with the U.S. Indian Health Service.

Council meetings are held every quarter. Tribal authorities for health are derived from 1868 treaties, the Snyder Act of 1921; The 1934 Reorganization Act; The Transfer Act of 1955; The Indian Self-Determination Act of 1975; and The Indian Health Care Improvement Act of 1976.

Mr. Chairman, our need for a new health care facility on the Pine Ridge reservation is severe. The existing Indian Health hospital was originally constructed in two phases. The original building is of wood frame with brick veneer and was constructed in 1932. A growing population and workload necessitated a second addition which was completed in 1960. The major inadequacies in the Pine Ridge facility relate to the age condition and functional design of the structure. The facility as a whole is functionally inadequate and deficient in its capacity to provide an environment for the current and future health care needs of the Oglala Sioux Tribe.

The condition of the old wing with its capacity from a fire and safety standpoint and its extensive high cost-maintenance problems makes the continued operation of the portion of the facility for any purpose a subject of real concern for both staff and patients as well.

The Denver Regional Office of Engineering, Facilities and Construction (ROFEC) has an official estimation that it would take \$2.2 million to restore this old facility into a semblance of what a hospital should be today. If this were to be done the facility would still be outmoded and suffer from cramped, poorly located and poorly arranged spaces. In its present condition it does not serve the health needs of the Oglala Sioux Tribe.

Our major health problems are many for inpatient ambulatory and contract health care. Leading for hospital admissions are: Complications of pregnancy, childbirth, injuries, poisoning, diseases of the respiratory and digestive system, mental disorders, suicide attempts, alcoholism and diseases of the circulatory system. In ambulatory care, leading are diseases of the respiratory system, accidents, poisoning, violence, ear diseases, pregnancy, childbirth disorders, nutritional problems and parasitic diseases.

In contract health where our current resource deficiency is 70 percent, health problems are mental disorders, injuries, poisoning, disease of the nervous system and sense organs, complications of pregnancy, childbirth and diseases of the respiratory system.

Mental disorders, alcoholism and drug abuse are our number one health problems identified under contract care. All patients have to be referred out resulting in more than 4,000 patient days in fiscal year 1981. Because of lack of space in the present facility, all outpatients with medical disorders are seen in a 10 year old converted double wide mobile home. The lack of space and trained staff prohibits proper mental health care which results in a high suicide rate among many of our tribal members.

The other area of concern is in our present surgery program, a program that is so vital to the well being of our Oglala people. We have one single operating room where all operative procedures are performed, including cesarean sections. A small room that was built to hold one patient serves as an I.C.U. and recovery room, the dividing partition consists of a curtain. For the most part all surgical equipment is old, outdated and not real suitable for OR work. Sutures, sterile supplies and expendable supplies are in short and inadequate supply and not of good quality when they are used.

Mr. Chairman, members of the committee, as result of these health problems and the great concern we have for our Indian people, we stand before you today in our request for a new health care facility on the Pine Ridge reservation to better serve our people. At one time we were on the list for a new facility, however, due to the moratorium on the construction of hospital beds, the bed methodology development and the IHS priority system, we suffered a four (4) year

set back. As a result of the new IHS priority system we are at the present time number two (2) on the list for a replacement hospital.

We have worked very diligently in the quest for a new hospital. It has been a joint effort in the planning of this replacement facility, between the Oglala Tribe and the Indian Health Service. To date, this joint and harmonious effort has produced a Program Information based on population and workload for 1990. The completed Program Information Document is a plan of a replacement facility that will be the location of a major comprehensive curative and preventive health care programs. This planned facility will also provide for a full range of outpatient and specialty clinics to the Oglala Sioux people.

The project will consist of a 48 bed inpatient complement consisting of 28 general medical, 8 pediatric, 8 obstetrical and 4 intensive care and coronary care beds.

Outpatient services will include full outpatient diagnostic and treatment facilities including emergency treatment. Specialty services such as family planning, well baby, otitis media, mental health and optometry clinics, as well as alcohol and drug abuse programs, nutrition services, general walk-in patient and tribal outreach services will be provided on an outpatient basis. Also included are dental services directed toward the prevention and correction of dental disease and the achievement of oral health.

Extensive community health services will be offered which will allow for the continuation of health services that are conducted in the communities and will work closely with tribal health programs.

The carefully prepared planning document indicates 119,123 gross square feet of space and functional requirements for this facility. The information in the planning document is based on medical needs with the analytical projection for workloads of 1990. The Program Information Document has been prepared in accordance with the Health Facility Planning Manual Vol. I, Indian Health Service.

We of the Oglala Sioux Tribe fully need this facility and as a result of the need and the planning we have set aside Tribal land in the amount of 80 acres. The Tribe working with Indian Health staff have initiated a site survey. The site survey has been completed by the Denver Regional Office of Engineering, Facilities and Construction.

Gentlemen, as you can see we have done our homework and would like to get the project started. Today we respectfully request funds of \$1,390,000 for the design and development phase of a replacement facility. This amount is supported by the Oglala Sioux Tribal Council, Indian Health Service and the Regional Office of Engineering.

Mr. Chairman, honored members of this committee, I want to thank each one of you today for allowing me to stand before you and speak on the health needs of the Oglala Sioux Tribe. Furthermore, I want to thank Dr. Rhoades, Director, IHS and members of staff for assisting us in the planning efforts of this facility. Thank you.

**RESOLUTION OF THE OGLALA SIOUX TRIBAL COUNCIL OF THE OGLALA SIOUX TRIBE
(AN UNINCORPORATED TRIBE)**

**RESOLUTION REQUESTING TO PUT THE NEW HOSPITAL FACILITY IN THE FISCAL YEAR
1984 BUDGET OF INDIAN HEALTH SERVICE**

Whereas, the Tribal Health Authority (Health Board) has been delegated authority by the Tribal Council, according to their Charter and Constitution and By-Laws, and

Whereas, the Health Board has been working hard to promulgate to the Washington, D.C. officials at hearings for a new hospital facility to be built on the Pine Ridge Reservation, and

Whereas, the need for the facility on the Pine Ridge Reservation is severe. The existing hospital was originally constructed in two phases. The original building is of wood frame with brick veneer and was constructed in the year of 1932. A growing population and workload necessitated a second addition which was completed in the year of 1960. The major inadequacies in the Pine Ridge hospital facility relate to the age condition and functional design of the

structure. The facility as a whole is functionally inadequate and deficient in its capacity to provide an environment for the current and future health care needs of the Oglala Sioux people, and

Whereas, since the health Board has been interested in their Indian people's health care, and they are requesting to have the new hospital facility be put in the fiscal year 1984 budget, now

Therefore, be it resolved, That the Oglala Sioux Tribal Council adopt this resolution to put the new hospital facility in the fiscal year 1984 budget as requested by the Tribal Health Authority (Health Board). The severe need is the new hospital facility to serve the Indian people of the Pine Ridge Reservation.

Senator ANDREWS. Our next group is Gordon Kitto, the program director from the Santee Sioux Tribe; Eagle Hunter from the Cheyenne River Sioux Tribe; Pauline Tyndall from the Omaha Tribe; and Robert Philbrick, the chairman of the Crow Creek Sioux Tribe. Are the four of you here?

Do you have statements for the record? Now we can assure you that the statements are a part of the record as though you uttered every word and we would like to have you summarize them and perhaps you can answer a few questions. Would you begin?

STATEMENT OF GORDON KITTO, PROGRAM DIRECTOR, SANTEE SIOUX TRIBE OF NEBRASKA

Mr. KITTO. Sure. I am Gordon Kitto. I am representing the Santee Sioux Tribe in Nebraska and we have prepared a position paper. I would like to summarize, but I would also like to read my opening statement and my closing statement.

Senator ANDREWS. Fine.

Mr. KITTO. In a recent letter from Senator Barry Goldwater, dated April 13, 1983, to the President of the United States, Senator Goldwater stated:

I think we pay far more attention to the human rights of people living in the countries of South Africa, Central America, or you name it, than we pay to the human rights of Indians living within the States.

And in closing I would again like to quote Senator Goldwater's letter to the President:

And so it goes, Mr. President, on, and on, and on, and yet all we hear about human rights in Washington are the abuses heaped upon people living in countries a thousand miles away from us. Of course we hear about the abuses heaped upon some of our people within the United States. But I'm talking about the Indians, Mr. President, people who were here long before our forefathers ever heard of this part of the world or thought of coming here. I am not speaking about, 'Lo' the poor Indian and what we have done to him in taking his lands. That is beside the point. What we are talking about is the moral question. What do we do about being decent to these people? What are we doing about educating them? What are we doing about providing help for them? What do we do about living up to the obligations we have established for ourselves in dealing with countries around this world? The Navajo Tribe, for example, represents 17½ percent of the national Indian population but receives only 13 percent of the total Indian budget.

I am making this personal plea to you, Mr. President, and I am including it in a letter to Secretary Watt, who I know understands this problem, to Secretary Heckler, and I am also putting it in the Congressional Record and making it available to the Select Committee on Indian Affairs, because, as a member of the United States Senate, as an American citizen who has lived most of his life with these Indians, I am just plain fed up, sick and tired of the neglect of these

people while at the same time you are asking us for millions, hundreds of millions, yes, billions of dollars to give to people scattered around this world to help establish human rights. Please, Mr. President, let us establish something in our own backyard that we can begin to be proud of before we wander around this earth trying to teach other people how to live and how to act toward each other. Let us act toward each other in this country like we really mean what we talk about.

Senator ANDREWS. Gordon, that is an excellent statement. I had a chance to briefly look through the total statement.

What percent cut do you feel the health service funding has received in your area?

Mr. KITTO. Basically the funding we have is very minimal at the Santee Reservation. If we look at the overall objectives of IHS and then look at the services received at the local level we do not receive anything.

We have one doctor coming down once a week. If we have any sick people we have to transport them 90 miles or contract them out and then if we contract them out we have to get special permission from the Wagner unit to get contract care, and if we cannot get the right person, we deal with them the best way we can.

Senator ANDREWS. So if you have a medical emergency and go to the medical hospital, the Indian Health people say you should have come to see them first?

Mr. KITTO. That is right.

Senator ANDREWS. It is a pattern that goes on whether you happen to be on a reservation in North Dakota or Arizona.

Mr. KITTO. North Dakota, Arizona, all over this Nation.

Senator ANDREWS. What is the key thing you would change if you happened to be, all of a sudden, named the director of the Indian Health Service?

Mr. KITTO. I think that in order to do that a person would have to be on a level of Secretary. Not Assistant Secretary, but a Secretary, where you would be able to make decisions that would be followed and not lost in a maze of bureaucracy.

I would think then that the director, if he had infinite wisdom, would let decisions be maximized at the local level. I think that we local people have enough education, fortitude, knowledge, et cetera, that we can make a decision concerning our own people which would be better for them than what people can make 1,000 miles away.

Senator ANDREWS. In other words, you feel that the Indian Health Service itself is being ignored in the overall bureaucracy?

Mr. KITTO. I firmly believe that. Anything that deals with Indian country is pushed under the table.

Senator ANDREWS. So that the problem really is in the lack of attention paid to the Indian Health Service even more than it is within the Indian Health Service.

Mr. KITTO. That is correct. I think that if the Indian Health Service had the positions by which they could operate in a very positive manner they could do that. I do not have any doubts about that. But they are so stifled by regulation, paperwork, et cetera, that you know their hands are more tied than mine.

Senator ANDREWS. Thank you. That has been most helpful.

[The position paper follows:]

POSITION PAPER OF THE SANTEE SIOUX TRIBE OF NEBRASKA, SUBMITTED BY GORDON KITTO IN BEHALF OF RICHARD L. KITTO, CHAIRMAN

In a recent letter from Senator Barry Goldwater, dated April 13, 1983, to the President of the United States. Senator Goldwater stated, "I think we pay far more attention to the human rights of people living in the countries of South Africa, or Central America, or you name it, than we pay to the human rights of the Indians living within our States."

As a matter for the record, the Santee Sioux Tribe of Nebraska will by resolution recommend approval of the reauthorization of Public Law 94-437.

In the area of health care, the status of the Indian to non-Indian can be summed up in a very few words. Other than the financial area, the Indian and non-Indian have the same concerns in the health service field. Distance, 20 to 30 miles to see the doctor. Fifty miles to the most updated and equipped hospital which does not operate on heart and brain patients. Lack of medical personnel, i.e.: doctors and nurses as well as the auxiliary staff in the area.

The nearest IHS or unit that serves the Santee Sioux of Nebraska is a distance of 90 miles. The unit sends a physician to Santee clinic once a week. Otherwise, all cases have to be transported there or contracted out.

With the economy being as it is, and the disparity of money which the Indian people can secure, we find that the non-Indian can purchase health insurance more readily than the Indians can. As the median and the mean incomes of the people in the County of Knox can attest, non-Indian, median income \$10,816, mean income \$13,624, Indian, median income \$4,040, mean income \$7,546. With 49.6 percent of the Indian people having less income than \$4,040 and depending on the definition, the unemployment level of the community can be interpreted as being 51 percent.

Our major health problems are many for inpatient, ambulatory, and contract health. Leading for hospital admissions are: supplementary classifications, complications of pregnancy and childbirth, injuries, poisoning, and diseases of the circulatory system.

In ambulatory care, leading are: disease of the respiratory system, supplementary classification, nutritional, circulatory, accidents, and pregnancy and childbirth disorders.

In contract health where our current resource deficiency is 70 percent, health problems are: complications of pregnancy and childbirth, injuries, poisoning, disease of the digestive system, disease of the genitourinary system, diseases of the respiratory system, eye disease, and accidents.

Alcoholism is our No. 1 health related problem identified under contract care and direct care. Many patients have to be referred out, resulting in more than 2,000 patient days in fiscal year 1981. Because of lack of space in the present facility, some outpatients are seen in converted staff quarters. The lack of proper health care results in morbidity and mortality among many of our tribal members.

On a positive note, the CHR program is one of the most necessary and valuable components within the health and tribal operation program. It functions as the necessary life link between the reservation community and the IHS hospital. Other private hospital facilities and private doctors, which are virtually nonexistent on the reservation, with the exception of one RN employed by the tribe, and a once a week visitation by an IHS physician, pharmacist, and RN at our clinic.

The main function is stated in the title program, community health representative.

1. The CHR provides clear communication between the community and the professional health staff.

2. The CHR provides essential assessments and information concerning health needs, by making regular home visits, if further medical attention is necessary the CHR arranges for professional medical health care.

3. The CHR provides 24 hour health care on an as needed medical alert basis. Within the scope of the prior three mentioned topics, the CHR performs the following duties:

A. The CHR provides health care instructions.

B. The CHR provides first aid as needed.

C. The CHR is a trained certified CPR and provides CPR when necessary.

D. The CHR provides technical procedures, i.e.: injections, dressing changes, etc.

E. The CHR provides school care and health education, i.e.: flouride mouth-wash, lectures, educational films, etc.

F. The CHR provides health and dental education to the community and schools under the supervision of a qualified physician and/or optometrist.

G. The CHR provides transportation for emergency cases, scheduled appointments if the patient cannot transport themselves because of age, medical incapacitation, or financial difficulties.

H. The CHR provides ambulatory services for patients when other EMS personnel or EMS volunteers are not available.

If, we look only in the service area of the Santee Sioux of Nebraska at the existing inadequacies in all the areas, we would and have found that the goals of IHS have been met at a minimal level.

This can be attested to by a quote from Senator Goldwater's letter to the President in which he said that an Indian leader had made this statement, "In all my years as a tribal leader I've never seen such inconsistency in Indian policy." The congressional committees must exert more control over the Federal agencies responsible for delivering services or there will simply be no services left. Also, Senator Goldwater stated that, "As a matter of fact the Indian health service has refused to release funds appropriated by the Congress in the fiscal years 1982 and 1983 for planning and design of hospitals."

On the Santee Sioux of Nebraska's Reservation the only improvements in the health services were made through the CHR program.

On one hand the IHS would put in a water system on the reservation and did not plan for funds which at the time IHS knew that the tribe did not have the wherewithal in cash flow to maintain the water system in working order or prepare the tribe technically for the maintenance of the water system.

We, the Santee Sioux Tribe of Nebraska, are aware of the short fall in administrative clout of the director in hierarchy of bureaucracy. We would recommend that the Director of Indian Health Service be on line as an Assistant Secretary in the Department of Health and Human Service. Also, we would recommend that decisionmaking powers be maximized at the local level.

In closing, I would again quote Senator Goldwater's letter to the President. "And so it goes, Mr. President, on and on and on, and yet all we hear about human rights in Washington are the abuses heaped upon people living in countries thousands of miles away from us. Of course, we hear about the abuses heaped upon some of our people within the United States, but I am talking about Indians, Mr. President, people who were here long before our forefathers ever heard of this part of the world or thought of coming here. I'm not speaking about," lo, "the poor Indians and what we have done to him in taking his lands." That is beside the point. What we are talking about is the moral question; What do we do about being decent to these people? What are we doing about educating them? What do we do about providing health for them? What do we do about living up to the obligations we have established for ourselves in dealing with countries around this world? The Navajo Tribe, for example, represents 17½ percent of the national Indian population but receives only 13 percent of the total Indian budget.

I am making this personal plea to you, Mr. President, and I am including it in a letter to Secretary Watt, who I know understands this problem, to Secretary Heckler, and I am also putting it in the Congressional Record and making it available to the Select Committee on Indian Affairs, because as a Member of the U.S. Senate, as an American citizen, who has lived most of his life with these Indians, I'm just plain fed up, sick and tired of the neglect of these people while at the same time you are asking us for millions, hundreds of millions, yes, billions of dollars, to give to people scattered around this world to help establish human rights. Please, Mr. President, let's establish something in our own backyard that we can begin to be proud of before we wander around this Earth trying to teach other people how to live and how to act toward each other. Let's act toward each other in this country like we really meant what we talk about.

Senator ANDREWS. Mr. Eagle Hunter, we have your statement. It is an excellent one. What would you say in addition to that?

STATEMENT OF EAGLE HUNTER, CHEYENNE RIVER SIOUX TRIBE

Mr. EAGLE HUNTER. (Mr. Eagle Hunter speaks in native language.) I have come here in behalf of the Indian people so that you will hear us and you will help us. That I ask of you.

Our population on the Cheyenne River is 4,649 and our reservation contains 2.8 million acres. From the farthest distance on both sides which the Indian Health Service is located on, it is 80 miles from the west side and 70 miles from the east side. We have an unemployment rate of 48 percent. It used to be 63 percent, but through the efforts of the tribal council we brought that unemployment rate down.

The problems that have been discussed we know and we can provide problems and we can also provide you the solutions and we have alternatives, but the only thing that we all need, like all the other reservations, are the funds.

We are in the process of contracting the entire hospital and this is in the hopes of eliminating the problems that are presented here. This would alleviate the problems at the local level and, like all the reservations, we do not like the services that the Indian Health Service hospital is providing and one way of trying to solve some of them is by contracting.

Senator ANDREWS Your statement is excellent. It also points out that you strongly oppose the proposed shift in Indian Health Service policy that would make Indian Health Service the last payer of medical costs for eligible Indians.

Earlier on, I asked if some of the other tribes had received the report of the task force on contract health care. They had not. Obviously you have seen it. You feel that it is certainly a move in the wrong direction as I understand it.

Mr. EAGLE HUNTER. Yes. As I stated before, our unemployment rate is at 48 percent and as of July 1, 1983, the immediate medicaid that the State would require the recipient to pay is 20 percent of the cost of seeing a doctor.

Senator ANDREWS. Right. Well, in fact it says: "We move toward maximizing third party cost," which means that they will be later and later in making their payments and more and more burden will be put on the tribe and the tribal member.

Mr. EAGLE HUNTER. What this would amount to would be if the Indian people cannot pay for their health care services, then the tribes would be forced to pay all of it, and following that, the tribes would probably go bankrupt because of trying to keep their Indian people alive.

Senator ANDREWS. That is true and it flies in the face of the old treaties as we pointed out earlier.

[The prepared statement follows:]

PREPARED STATEMENT OF THE CHEYENNE RIVER SIOUX TRIBE OF SOUTH DAKOTA

The Cheyenne River Sioux Tribe of South Dakota would like to bring to the Committee's attention proposed changes in the Indian Health Service program that are of great concern to us. As you are aware, Indian communities continue

to have enormous unmet health needs on the reservations which Congress has attempted to alleviate through direct and contract care services provided by the IHS. It is against this background that we urge the Committee directed at obtaining "third party resources to cover the cost of medical care for IHS eligible patients."

In a February 1983 memorandum the Director's Task Force on Contract Health Services submitted to the Director of IHS its "Recommendations for Improved Management of the Contract Health Services Program." One of the Task Force recommendations is for IHS to "aggressively implement its policy of being the last payer available third party resources (e.g., Medicare, Medicaid, VA, private insurance, and Crippled Children's Funds)."

We strongly oppose the foregoing proposed shift in IHS policy which would make IHS the "last payer" of medical costs for eligible Indians. When Congress enacted the Snyder Act of 1921, authorizing IHS appropriations, Congress acted pursuant to its Federal trust responsibility to provide for the health and welfare of Indian people. This trust responsibility is based on long standing treaty rights and land concessions which Indian people made. IHS, therefore, is not a purely discretionary program which can be unilaterally altered to the detriment of Indian people. The direct and contract health care services provided by IHS on the reservations are mandated by treaties and Federal independently of any other Federal health care program. The proposed policy shift making IHS the "last payer" is inconsistent with the purpose for which IHS was created, namely, to ensure that a health care program existed on the reservations to provide free medical services to Indian people.

Second, we oppose the proposed policy shift towards "maximizing third party resources" because the likely effect will be to require Indians to pay some, if not all, of the up front cost for medical care and then seek reimbursement from the state or federal government or private insurers. Indians living on reservation are extremely poor people who cannot afford to pay for much needed medical services, and who simply will be unable to cover up front costs of any magnitude.

If the IHS proposal is adopted many Indian people would be forced to forego most medical treatment including almost all preventive care. Specifically, on the Cheyenne River Sioux Reservation the average annual income is \$5,459; recent statistics reveal that the number of miscarriages has increased from 6.59 per 1000 live births in 1981 to 61.2 per 1000 live births in 1983. Field health clinic screenings determined that in one community 90 out of 133 children were iron deficient and 56 out of 107 were deficient in another community. The average poverty level income of these families would make medical care unaffordable if the IHS proposal is adopted. Moreover, the examples we have cited make clear that our urgent health needs cannot be subjected to budgetary concern that would deny us the services we need.

Third, we strongly oppose the IHS proposal requiring that Indians who are eligible for medicaid apply for such in lieu of the free IHS care that exists presently. We have been informed by the South Dakota Department of Health that as of July 1, 1983 all medicaid recipients will be subjected to a "co-payment" program whereby the recipient must pay some pre-determined percentage of the medical cost at the time of treatment. As we have stated, such a proposal will inevitably result in Indians obtaining much less medical care because we cannot afford to pay for such services.

Finally, we strongly urge the Committee to reauthorize appropriations under the Indian Health Care Improvement Act to insure continued assistance to tribes wishing to assume responsibility for operating their own health care programs. The IHCI Act has helped tribes meet their health needs by enabling us to contract directly with the IHS to deliver services on the reservation. In light of the significance of Indian health needs, continued appropriations for the IHCI Act are critical to the delivery of health care for our people on the reservations.

For all of the foregoing reasons, we strongly urge the Committee to reject any IHS proposal that would impose on Indian patients a pre-payment requirement as a condition to receiving medical treatment which Congress sought to provide for through IHS.

Senator ANDREWS. Pauline Tyndall from the Omaha Tribe. We have your statement. It is an excellent statement. We appreciate it.

STATEMENT OF PAULINE TYNDALL, OMAHA TRIBE

Mrs. TYNDALL. First of all I would like to thank you for allowing us to participate here and also to apologize for Mr. Elmer Blackbird, the tribal chairman's inability to come due to a death.

Senator ANDREWS. We can understand that, but he sent a most able representative.

Mrs. TYNDALL. Well, I certainly hope so. I was the backup to answer the questions because he was going to be the presenter.

But we tried to cover most things, the major issues, and the reauthorization of Public Law 94-437 is very important. It is probably the most important act ever to be presented because it gave promise that the health needs of Indian people would be met. However, the funds were not adequate and it did not last too long so we are very hopeful that it might be reimplemented and these funds might become available.

The Omaha Tribe has been involved in the Public Law 93-638 project since 1977. Under an EDA grant we were able to obtain a facility which allows us to provide full ambulatory care and a full nursing home and this has been a very successful effort on our part.

I sympathize with the testimony that I heard here today. The horror stories that you heard are still existing because at the time we were in the same predicament. But, with our own self-determination we are providing our own health care and we have been able to make great progress.

Senator ANDREWS. Have you had any problems in this contracting process?

Mrs. TYNDALL. Yes, we have. I think I would like to address that in that the recent budget cuts have severely blocked our efforts at self-determination.

Senator ANDREWS. What efforts have you made?

Mrs. TYNDALL. We had, in 1982, 4 percent reductions in our hospitals and clinics and we have an additional 4 percent reduction this year and this is quite a considerable amount of money. We do not have adequate funding in contract health. We use every resource possible. The tribe has all of their employees in Blue Cross-Blue Shield. We have third party resources that we can collect but this still does not provide the funds to pay all of us.

Senator ANDREWS. You say the tribal employees have Blue Cross-Blue Shield?

Mrs. TYNDALL. Yes.

Senator ANDREWS. In your experience are there many other tribal patients that carry private insurance coverage?

Mrs. TYNDALL. Very few. I would say none.

Senator ANDREWS. Medicaid coverage?

Mrs. TYNDALL. Medicaid and medicare.

Senator ANDREWS. Could you estimate the number of patients that carry such insurance?

Mrs. TYNDALL. The Blue Cross-Blue Shield?

Senator ANDREWS. Yes, or medicare, medicaid. How many are paid for by others?

Mrs. TYNDALL. I would say a close estimate would be about 30 percent.

Senator ANDREWS. That is most helpful.

Mrs. TYNDALL. I would like to state further that there are emerging diseases among Indian communities and one we have been very concerned about is the aftermath of alcoholism, diabetes. We have a very high percentage of diabetes and I think most Indian communities do and we are seeing new diseases that we have not coped with in the past. Among our children in 0 to 4 we have seen a 50-percent increase in multiple handicaps. These children, of course, are going to be with us for a long time to come and it is very vital that we provide services that rehabilitate them to the best of our abilities and hopefully work out preventive care in the future. I do not believe that we have seen a peak in that situation yet.

I think tribes are not fully aware of what this can imply for years to come. It seems to me that we have a lot of criticism of Indian Health Service. Primarily the people in the field, or even the people in the central office, seesaw back and forth. Central office puts orders down to the area office and the area office, of course, then superimposes them on us. Somewhere it has to stop.

I think, also, the same thing is happening with them in the higher-level agencies and I do believe that bringing the director of Indian Health Service into a higher-level position of authority certainly cannot do anything but help the situation.

We feel that we are doing a very positive thing. We would like to set our project up as an example, a pilot project, if you will, on how Indians can self-determine using the authority of Public Law 93-638. The mechanics to do the job are there. There just are not enough regulations to cure all of the needs in the area because our 638 project does not receive all mandatory funds nor do we receive all items.

Some of them said they have had alcoholism money. For the last 4 years we have had none. What money that we can glean we get from the State. It is a battle royal to get money from the State and they are very minor sums, so there are a lot of health needs. There are a lot of inequities in distribution.

I think we all know that it is something that we have learned to live with, but I do feel that there can be some very positive things if we just leave our budgets alone, leave them at the level they are now, and stop cutting back because I do not think they are going to do any good, but create further need down the road.

Senator ANDREWS. Thank you very much.

[The prepared statement follows:]

PREPARED STATEMENT OF OMAHA TRIBE OF NEBRASKA, ELMER J. BLACKBIRD,
CHAIRMAN, SUBMITTED BY PAULINE TYNDALL

Honorable Senators:

I. Reauthority of Public Law 94-437.

The bill was probably one of the most important documents ever presented and gave promise that some of the basic health needs of Indian people would finally be addressed.

1. Number of Indian Health Professionals are increasing, but not to the extent needed, without specific funds for training will come to a near halt.

2. Back log of Unmet Health needs is increased to a extremely high level and new and emerging needs are not being met as rehabilitative and habilitative care.

3. Health facilities are obsolete and inadequate to provide safe delivery of care. The funding provided by 94-437 is essential.

4. Access to Health Services is important as all Aberdeen Area reservation hospitals are located vast distances and transportation is limited, roads very poor and extreme changes in climate make travel risky for patients. Urban Indians must have some type of support for those who are living in the inner city, and usually do not have jobs that are steady or pay enough for insurance, but even so interfacing with the system is difficult at best.

II. Health Status of Indian in comparison with United States as a whole. The American Indian has made some progress over the past decade in certain disease categories.

However, the crisis treatment is not conducive to prevention and early intervention, they must go hand in hand. While we complacently put bodies back together again, the main causes are not being addressed adequately or properly, that of alcoholism and diabetes.

The after math of such disease and the socioeconomic problems on the reservation has brought an increase in the number of multi handicapped children, suffering from various syndromes. The 0-4 age group rates have increased 50 percent over the past 3 years, and we suggest the peak has not yet occurred. That these special children will be with us for a long time to come, creating further inroads on our health care dollars. It behooves us to do something about it now. We need programs of physical, speech and occupational therapy. Rehabilitative and habilitative care is essential to the impact on this continued cost in the future.

Attempts are being made to start programs to meet this need, but there is just not enough dollars or expertise to make it happen. Nor is there space or equipment.

III. The recent budget cuts have severely blocked our efforts at self determination in health, while the Omaha Tribe of Nebraska has one of the most viable projects in the nation, we will be forced to curtail our progress. This past 2 years we have received a total of an 8 percent reduction in our hospitals and clinics budget.

93-638 Tribal Projects were selected this year to bear the burden of cut-backs. While the Omaha Tribe has been in operation for five years under a "638" contract with I.H.S., they have found a lack of support from the appropriations. We did not have line items from specific appropriations as: Mental Health, Alcoholism, Maintenance & Repair, equipment purchase. We do not benefit normally in Unmet Surgical needs money, student health care fund, until this past week when the Contract Health Service allocations for the Center were reviewed. In all fairness to 93-638 projects all the support provided to the IHS hospitals should be provided to the Tribal programs, too often the program is not fully supported in this manner. There needs to be a review of the 93-638 Health contracts with Tribes to ensure full support is given the Tribes, if this is not done your failure clause is built in. Regulations do not specify this and it may be assumed it is happening but in reality does not.

We need to expand facility space to enable us to generate 3rd Party funds to offset a sizable portion of our current cost. We have a model project, one which can well be used as a base for Tribes health care systems.

IV. The continuation of the Community Health Representative program is vital to our system.

Transportation is vital to the delivery of health care. Our C.H.R. program was restructured this past year to see if their function could be absorbed by other departments. We found this not to be feasible. Due to the fact they provide a unique service to the Community in day to day contact, services and interface with health professionals. They provide the human element in contact with the patient by being able to communicate with, and for them.

Our program has (8) positions. The positions are assigned under a new title: The Patient Service Program.

The Patient Referral Service of the Program; (3) staff provide all transportation to referral hospitals for renal dialysis, surgical, dental surgery, O.B., specialty clinics in fact for all secondary and tertiary care.

The Patient Service Staff are assigned thus:

(1) Patient Referral Service Coordinator—provides general supervision to all staff for report and general program requirements and maintains schedules for referrals to other hospitals.

(2) Patient Service Aides assigned to the Community Health Nurse, who supervises.

1—To Diabetic Clinic home visiting, and contact with Diabetics on diet etc. Maintains appointments and provides nutrition education.

1—To the "special kids" program where the pre-schoolers are brought in for therapy and care. This PS Aide provides follow-up in the homes of the children in the areas of speech, occupational and physical therapy.

(1) Patient Service Junior Aide provides $\frac{1}{2}$ time coverage for the dental clinic, $\frac{1}{2}$ time for health education.

(1) Patient Service Senior Aide provides support and patient advocacy in the Nursing Home and for the Senior citizens.

If the CHR Program is not funded, these positions will go, with no funds or means for replacing them.

They provide services vital to our health system, which existing staff can not provide.

IV. The Director of Indian Health Services, should be elevated to a position of Assistant Secretary in the Department of Health & Human Services. Providing a more direct line to the Director of H&H Services. The problems of Indian Health have been with us too long, providing a more direct access will help to cut-out some of the delays that bring so much criticism to the Division of Indian Health Service. It would serve to expedite processes.

V. The Indian Health Service Task Force on Contract Health Services has made some recommendations on eligibility. None of which seemed suitable, it leaves many unanswered questions.

The HSDA's (Health Service Delivery Areas), is a method which could make a more equitable distributions of dollars. The enrollment system may be effective, however, additional staff will be needed. Verification of blood quantum is necessary, and blood degree essential. These are problems which should be addressed but it will be most difficult.

Residency in a HSDA is important as a person leaving the area have an eligibility span, this should be true of those returning when should their eligibility commence?

A census should be taken every fourth year on the reservation as our Omaha Tribe Census is nearly 200 percent over the last 80 census allowed. Whereas other discrepancy occurs, in reservations claiming on or near Indian populations and providing only the members of their Tribes with Contract Health Service.

Senator ANDREWS. Our next witness is Robert Philbrick, the chairman of the Crow Creek Sioux Tribe. Welcome, Mr. Chairman.

STATEMENT OF ROBERT PHILBRICK, CHAIRMAN, CROW CREEK SIOUX TRIBE

Mr. PHILBRICK. Yes. Thank you, Senator Andrews, because this is quite an honor to come up here to North Dakota from South Dakota and meet the Senator. Even though I was in Washington several times I never got to go to your office, but I think from now on I will go there because I wish our Senators would hold these kind of hearings in South Dakota and then we would not have to come up here.

Senator ANDREWS. I hope you spent the night in a hotel in Grand Forks and did all the other things.

Mr. PHILBRICK. I did. I had a good place.

Senator ANDREWS. We have tougher winters than you do down south so we need all the help we can get.

Mr. PHILBRICK. I know. I was here in February and I witnessed some of it.

Senator ANDREWS. Well, this is a very mild winter. You ought to see it when you are basking in that banana belt weather and so on.

We have your statement. It is an excellent one, Mr. Chairman, and we will be glad to hear anything additional that you might have to supplement it.

Mr. PHILBRICK. Well, first of all, I guess to save time, and I guess this is important to you folks to have the time, I think all the previous people who have talked mentioned all of the things that I certainly will stand behind.

Like the INMED program here. I have come here and had some meetings here with the people and I have looked over facilities and I heard these young men talk and I certainly appreciate things like this that are going on.

I have been in tribal politics since 1934 and I am 71 years old now and I feel like I am going toward the end of my career as far as being on a council, but I am the chairman now of the Crow Creek Sioux Tribe.

Now the things that I feel that are going on in the nature of complaints is this man who is in the White House, Mr. Reagan is—I think what he wants to do is make more missiles and fire them from Nebraska and Wyoming. He wants to put 100 or 200 missiles in there and then cut the budget. He has no regard, it seems like, for the Indian people who were the first Americans.

Like you mentioned here about a treaty. I feel that some of these treaties are still intact and they should be honored and I heard you say that we have a treaty and you were to serve Indian people for their health and their welfare and also develop their reservations so that they can be self-supporting. We are trying to do these things but it is very difficult when everything is being cut. If we can get more money into health that would be good. We have a contract with Indian Health on some of our hospitals but it is very difficult for Indian people to go to these hospitals now because of the cuts and because we can only go in case of emergencies. In Chamberlain, S. Dak., where Crow Creek is close to, they are saying we owe them maybe \$150 or \$1,000 from the past that Indian Health did not pay. We feel that some of these are legitimate bills and we would surely like Congress to see if they can consider paying some of these bills, if not all of them, because it makes it difficult for Indians to go down there because they say: "If you do not have any money you cannot come in and if you do not have an emergency you cannot come in." I feel that if there is any help that your committee could give to this, I would sure appreciate it. I support everything that has been said and I appreciate your time.

Senator ANDREWS. We appreciate your statement very much, Mr. Chairman. It will be a big help to us.

You know, sometimes, unfortunately the story gets out that we can just make these things appear as if by magic. It sometimes works that way, but usually not, and usually in the Congress it does not make much difference whether you are a Democrat or a Republican or what. The changes that you seek have to be justified.

We build water projects. We call them cost benefit ratios. We talk about the needs of individuals and that is why we come out for these hearings.

I started 18 or 20 years ago in the Congress. In fact I have served now under about five Presidents. Mr. Chairman. I started under Jack Kennedy and I believed a long time ago that you ought to come out and hold courthouse hearings and we did that to get a little closer to

people. Then we put in an 800 number so you can call my office. And you will notice that we have a mobile office in the State and that is why I brought these people out in the field, because we need the best possible information and you cannot get it from the professionals down in Washington.

It is an imposition on you, Mr. Chairman, and your other fellow chairmen and fellow tribal officials to try to whistle you all into Washington. It is a lot easier to see us out in the field if we are going to be representatives of the Government.

So you contribute by coming in and making the statement you did and it will be a part of the record and we will use it for the things we hope we can do. We cannot guarantee anything, but there is a better chance of success because of the fact that you have given your case. Thank you for appearing.

Mrs. TYNDALL. Mr. Chairman, one thing I would like to emphasize for our program. I think it is in jeopardy. I do not think it is included in the 1984 budget and I would like to mention that.

Senator ANDREWS. We realize that.

Mr. KITT. Senator Andrews, the tribal council would also like to recommend reauthorization of the program.

Senator ANDREWS. Thank you very much.

Mr. PHILBRICK. Mr. Chairman, I would like to add one more thing here about this Dr. Rhoades, the director in Washington. It seems like even though he is trying to do a good job, I feel that he is not in a position where he can make a decision and I think from the top he is telling us to cut down on things, but that he is not able to count these things.

Now we are in line with the clinic and nothing is being said about it. He did not say anything about it. We met with him in Washington and he did not give us any good response that we are going to get the clinic. We are also supposed to get a new water system in our agency and I just want to mention that.

Senator ANDREWS. I understand that. We thank you.

[The prepared statement follows:]

PREPARED STATEMENT OF THE CROW CREEK SIOUX TRIBE, SUBMITTED BY
ROBERT PHILBRICK, CHAIRMAN

Mr. Chairman, Honorable members of this Committee, my name is Robert Philbrick, Chairman of the Crow Creek Sioux Tribe, located in central South Dakota. I appreciate this great opportunity to appear before you today and to speak on the health needs of my people.

First of all, I would like to give you some background on my reservation. The Crow Creek Tribe is unincorporated and did not adopt the Reorganization Act of 34 and is operating under its treaty. The Crow Creek Sioux Tribe operates under a constitution and by-laws which was ratified and adopted on March 11, 1949 and was approved by the Secretary of the Interior on April 26, 1949. There are three (3) districts, seven (7) council members and the Tribal Chairman who is elected at large.

The reservation comprises an area some 60 miles long and 30 miles wide. The land is mostly arid with rolling hills, the western border of the reservation is the Missouri River. The principal community on the reservation is Fort Thompson, where approximately 60 percent of our population lives. Total Indian population estimates for 1983 is 2,516 people. Of this population about 40 percent of our people still live in sub-standard housing. The average is 4 rooms per house with an occupancy of 8 individuals per housing unit. Per capita income for Tribal residents has the dubious distinction of being the third lowest in the nation. Recent data shows that unemployment on the reservation is about 90 percent. With more

of our enrolled members returning to the reservation and as a result of the low economic status, maintaining proper health care standards becomes a major problem.

Mr. Chairman, in the 1920's we did have a hospital that was of wood frame and later was destroyed by fire. In 1935 the Bureau of Indian Affairs constructed a twenty (20) bed hospital, a surgery room, outpatient clinic and living quarters for nurses and doctors. This facility served our Indian people well and good health care was provided.

In the late 1940's the Pick-Sloan plan was approved which resulted in the Big Bend Act of 1962 (Public Law 87-735) and the construction of the Big Bend Dam. The construction of this dam necessitated moving the entire township of Fort Thompson and the loss of our health facility. The Dakota winters are hard and severe, with temperatures ranging from -25 degrees to a high of 115 degrees fahrenheit. The hardships of a long winter greatly adds to the health problems of the reservation. Since no public transportation exists on the reservation and less than 20 percent of the Indian population own automobiles, even getting to adequate health care presents a problem.

Mr. Chairman, on the Crow Creek Reservation, we do not have any inpatient facilities, the nearest is in Chamberlain, South Dakota, which is some 25 miles distant. The major problem we have on the reservation is ambulatory and preventative care.

The present ambulatory and preventative care programs on the reservation operate out of scattered locations in the Fort Thompson community. The clinical portion is of wood frame construction, a converted two bedroom house that was built in 1960. The first floor, about 960 square feet, contains pharmacy, two exam rooms, reception and waiting areas. One of the exam rooms also serves as lab space when the need arises. The basement, also about 960 square feet contains storage, a furnace room, a room with three desks in it and a small two chair dental clinic. Waiting space for dental is four chairs in the hallway. There are no emergency exits in the basement, nor are there any facilities for the handicapped. Administrative and preventative health care is provided in a BIA building across the street, in what was formally the tribal court room. The same building also houses the BIA and Tribal jail. A Tribally operated ambulance service operates in another building some distance away.

Most of the major inadequacies in the Fort Thompson facility relate to age, condition and functional design of the structure. The facility as a whole is functionally inadequate and deficient in its capacity to provide an environment for the current and future health needs of the Crow Creek Sioux Indian people.

The condition of the facility is a hazard from a fire and safety standpoint and its extensive maintenance problems makes the continued operation of this facility a subject of real concern for both staff and patients. The Denver Regional Office of Engineering, Facilities and Construction (ROFEC) has cited so many deficiencies in the structure that it is just not feasible to renovate it for health care purposes.

The major health problems my people suffer from are: Diseases of the respiratory system, accidents, poisoning, violence, ear diseases, diseases of the circulatory, digestive systems, nutritional, infective and other parasitic diseases. The meager contract health funds received are spent on health problems with the respiratory and digestive systems, complications of pregnancy and childbirth, mental disorders, and other illness defined conditions.

Patients needing special services such as X-ray and laboratory all have to be referred away from the reservation. We cannot even handle emergency cases and they must be transported elsewhere.

Mr. Chairman, despite our very limited natural resources, the high unemployment rate, the desolate and rural area we live in, the health problems we suffer from, the Crow Creek Sioux are still a noble and progressive people. We too, would like to enjoy a healthful life, it seems that our elderly suffer the most from lack of adequate health care. When they become ill, they have a difficult time even getting to our small clinic, let alone being referred off the reservation for health care. Young mothers face the same problems as the elderly.

Mr. Chairman, members of the Committee, as a result of the health problems and the concern I have for my Indian people, my purpose today as I stand before you is a request of a replacement Health Care Center to be located in Fort Thompson, South Dakota.

The quest for this health center dates back several years. The Tribe and the Indian Health Service have long recognized the dire need for a replacement fa-

cility and had a joint effort in the planning of such. As a result of the Indian Health Service priority system we are number two on the list for a proposed replacement. As a result of our mutual planning we have a completed and approved Program Information Document. In addition to a Program Information Document, The Crow Creek Sioux Tribe has set aside a parcel of Tribal land in the amount of twenty (20) acres. The Denver Regional Office of Engineering has already completed phase one of the site survey.

The Fort Thompson Health Center will be the location for major comprehensive curative and preventative health care programs planned to meet the total health needs of the Crow Creek Sioux Tribe. This new facility will provide the needed general medical and specialty care. In our planning assumptions, the workload and population will be 2900 people and close to 12,000 outpatient visits in 1989.

The health center outpatient services will include full outpatient diagnostic/treatment facilities with emergency treatment, casting and holding area. Specialty services, such as, well-baby, family planning clinics, nutrition services will also be provided.

An extensive community health and mental health program will be offered. This will include community health nursing, social services, health education, nutrition and community environmental health services.

The Program Information Planning Document calls for 19,544 gross square feet of space and functional requirements in the proposed facility. The planning has been accomplished in accordance with the *Health Facility Planning Manual* Vol. 1 Indian Health Service and also reflects current medical and professional philosophies, as well as current professional and accreditation standards by numerous professional organizations and agencies. The Indian Health Service and Denver Regional Office fully support the Program Information Document.

Mr. Chairman, as part of the testimony we are most grateful to Dr. Rhoades, Director of Indian Health Service, his planning staff and the Denver Regional Office of Engineering for providing the guidance and technical assistance in our planning efforts.

As you can see we have progressed up to a point. The second and most vital step is the reason why I am here today. The Indian people of the Crow Creek Sioux Reservation do need a new Health Center and we are requesting your utmost consideration for the funding of this facility. The amount we are requesting is \$2,740,000 for design, development and construction and an additional \$2,625,000 for twenty-five (25) units of staff quarters. These figures are also a result of our planning efforts. We have a plan and the land and now we need your support. We also anticipated that Congress will allow for the treatment of the local non-Indian population and that any third party resources collected would in turn be used back into the Health Center for purposes of supplies, maintenance, housekeeping and other areas where shortages would exist.

The Fort Thompson township was relocated above high water level which provided a grade school which is now condemned. Peoples lots cannot properly be identified due to the Corps errors in establishing the new Fort townsite.

Our water and sewer facilities are inadequate whereas much dollars were spent trying to improve an 8" water line. The sewer systems with lagoons which had to be repaired since they were built.

The House Appropriations Committee held hearings in April of this year, at which time I, as Chairman of the Crow Creek Sioux Tribe, testified and was given word by Congressman Yates that we would get our new clinic and since I indicated to him our poor water facility, he suggested I request a complete new water and sewer facility for Fort Thompson. I wish to add at this time our tribe living along the Missouri River have not had any adequate water system, so now we are asking the Committee to make a study and include the local rural area which will contain approximately 35 miles of water line for badly needed water. This water line will serve about 60 homes and ranches.

Also our health care on the reservation has been cut badly; we've been told we cannot go to the hospital unless it's an extreme emergency.

We the Crow Creek Sioux Tribe are under a treaty with the U.S. Government and the Government is responsible for the health care of our tribe. We have no funds for industry and no funds for development. We do not have the cooperation of the Corps to help develop the shoreline.

Mr. Chairman and Honorable members of this Committee, I want to thank each one of you for your valuable time, for allowing me here today and to speak to you on behalf of the Crow Creek Sioux health needs. Thank you.

HISTORY OF CROW CREEK HOSPITAL

Mr. Chairman: Sometime soon after the Crow Creek Sioux Indian Reservation was established, about the years 1910-1912, a lady from the eastern United States came to visit the Crow Creek Sioux and learned there were no health facilities on the Crow Creek reservation. Realizing there was a great need for health care as well as childbirth and other health reasons, this lady donated a certain amount of money to the Crow Creek Sioux to help build a hospital which consists of two (2) wards for patients, an emergency operating room and in/out patient room. Because the Lower Brule Sioux were just across the Missouri River, both tribes utilized these facilities. This hospital was given to the people of the Crow Creek Sioux Indian Reservation but the operating of this hospital was supervised by the Bureau of Indian Affairs until 1935 at which time it was dismantled into four (4) units for Bureau of Indian Affairs housing.

During the 1880's the United States Government had built a boarding school for the Crow Creek Sioux children which was in use until 1924 at which time it was condemned. A gymnasium the size of the 20-bedroom hospital the Crow Creek Sioux used to have was then converted into the hospital (the Bureau of Indian Affairs converted this into a TB unit, which the Crow Creek and Lower Brule Sioux Indians utilized until fire destroyed this unit in 1984).

IMPACT OF BUDGET CUTS TO IHS ON THE AVAILABILITY OF SERVICES, PERSONNEL, TRAINING, AND PRIORITIES OF TREATMENT

The Aberdeen Area has been severely impacted by the budget cuts imposed on the Indian Health Service.

The attached summaries show the conditions Service Unit by Service Unit caused by budgetary shortfalls.

The end result of this condition is the rationing of care to Indian people within the Aberdeen Area. Further evidence of the rationing situation is the backlogs in the dental, mental health, eyecare, and unmet surgery areas.

Special attention must be given to these grave situations in the Aberdeen Area, which currently only remain functional because of what one could term heroic efforts by physicians and support staff at all twelve Service Units. Examples are working long hours without compensation, doing two jobs or doing the work of two people as evidenced by CAP Lab productivity data, etc.

Budget cuts have hit the Aberdeen Area hard and recovery will take at least six to eighteen months. New staff will have to be recruited, services that have been eliminated reinstated, and predictability re-established.

Please consider the attached summaries in deliberations regarding funding and resource allocation.

PROGRAM ADJUSTMENTS—PIERRE SERVICE UNIT

I. Positions Vacant: 6. Value: \$153,531.

II. Services Reduced:

1. Owing to the lack of funds to maintain the facilities, the clinics have had to close down several times a month.

2. Poor road conditions have placed an additional strain on the services because of increased travel time and financial resources needed to travel to the clinics.

3. CHS reduced to priority I—funding available for 39 weeks of FY-83 25 percent shortfall, assuming there are no catastrophic cases.

4. Payments for eyeglasses are restricted to school age children one time only.

5. Mental health and social services are non existent because of staffing and budget problems.

6. The high number of vacancies caused morale to decline to a serious state, affecting patient care.

7. The State of South Dakota has decreased alcoholism funding, causing an increased burden on IHS resources (see Dr. Nutting's study, Winnebago).

8. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provisions of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

FUNCTIONS AND VALUE OF THE CHR PROGRAM

The CHR Program in the Aberdeen Area has benefited the Indian population immensely since its inception.

Correlations with the decline in inpatient days, the increase in outpatient visits, the increase in live births, the decrease in infant mortality rates, and the decrease in tuberculosis morbidity and the existence of the CHR Program are well documented.

Much, however, still remains to be done in the areas of alcohol abuse, drug abuse, mental health, and venereal disease, just to name a few. The CHR Program is one of the main links in the chain of events that leads to good preventive programs and the conservation of resources spent on acute care.

The CHR's are a positive link in the Indian Health Care system. They are usually members of the Tribes, whereas the Public Health Nurses and doctors often are not. Shared Tribal memberships and shared languages can establish an immediate rapport for the patient who might be anxious about his health or the need for medical care. This rapport can facilitate earlier medical treatment and provide a setting for individual or family health education.

The CHR's are an answer to the critical transportation problem on the Indian Reservations. The lack of dependable transportation is compounded by the great distances between homes and health care facilities on the Aberdeen Area's Reservations. The Community Health Representatives are, for many Indian people—particularly the elderly and women with small children, the only access to medical care.

The CHR Program is a cost-benefit program. Through the CHR's regular and frequent visits to elderly and homebound individuals, unnecessary inpatient medical costs can be avoided. The CHR's can provide homemaker services and certain medical treatment for the elderly who are unable to fully care for themselves in their own homes.

The CHR Program is vital to Indian people and continued full support of the Program is urged.

Attached are recommendations from the National CHR Program. The Aberdeen Area supports those recommendations and encourages their implementation.

FUTURE DIRECTION OF THE CHR PROGRAM

The National CHR Task Force Recommends:

1. That the CHR Program be continued.
2. That the CHR Program retain its unique qualities of providing services in areas of need, where no other program or resources is available, and that the program not be used to supplement IHS staffing.
3. That the IHS, cognizant of organizational constraints, utilize the perspective of Tribal people in enhancing program growth and development.
4. That the reporting system reflect credit for all services provided by CHR's, i.e., work performance as a dental assistant or as a sanitarian.
5. That the Task Force work in developing a CHR Policy Manual be continued with Area/Program and Tribal contractor participation.
6. That funds should be identified and committed at the national level for the effective directorship of the CHR Program which will provide for:
 - A. An IHS Headquarters Program Director position of equal status to other Headquarters Program Director positions.
 - B. A national training initiative that provides for Area-based training activities.

C. A national mandatory reporting activity.

Further, such funds should evolve from the current "set aside" for administration of this program in an amount not to exceed \$400,000. Once the budget has been determined for FY 1983 this CHR administrative budget breakdown should be distributed to CHR contractors.

RECOMMENDATIONS REGARDING METHODS FOR MEETING CHR TRAINING NEEDS

It is recommended:

1. That hospital corpsmen training be investigated (regarding Great Lakes area) and that IHS Headquarters followup on whether or not the training arrangement previously proposed is currently available for CHR contractor to take advantage of the training courses.
2. That a strong emphasis on training for CHR staff be continued as part of the total CHR program. This training should respond to training needs identified at the local level. Such training needs should be identified in CHR annual contract proposals with a "dollarized" plan that relates to the capabilities necessary to carry out the scope of work. Training requirements and funds should then be negotiated into the contracts. The National CHR training initiative should assist Areas in meeting those needs. Training should be recognized as an integral part of the program and certification/college credits should be given by the agency/institution providing training.
3. That every effort should be made by IHS to secure training funds from sources other than the CHR budget both within and outside of the IHS.
4. That a study with recommendations be conducted of past and currently available CHR training activities to determine their adequacy in meeting training needs.
5. That training and certification should be carried out in accordance with recognized standards of health care.

DEVELOPMENT OF RECOMMENDATIONS FOR METHODS OF ALLOCATING AND/OR REALLOCATING RESOURCES TO ACCOMMODATE FUTURE BUDGET INCREASES OR DECREASES

It is recommended:

1. That the Community Health Representative Program cannot endure further budgetary cutbacks.
2. That resource allocation should avoid competition as this serves to fragment the Indian communities.
3. That IHS should discontinue tapping CHR funding before allocation to American Indian and Alaska Native organizations, with the exception of those funds identified in recommendation No. (6) under Future Direction of the CHR Program.
4. That the Indian Health Service develop a methodology for the allocation of community health program resources that will utilize three program modules: (1) scope; (2) effectiveness; (3) needs. This methodology should be developed with the active participation of an advisory group consisting of Indian and Alaska Native Community Health leaders.

Program scope criteria should be consistent with those health care delivery settings, functions and areas which have been delineated for the CHR program by this Task Force.

Program effectiveness criteria should include factors which measure medical efficacy and cost effectiveness.

Program needs criteria should be derived from an array of RRM modules which represent community health care needs which are fulfilled by CHR program resources.

The development of this methodology should be done in a manner consistent with the staff paper entitled "Consideration Regarding Future Allocation of CHR Resources".

Furthermore, this methodology should be developed within FY 1983.

5. Recognizing the evolution of the CHR Program from a community outreach liaison health care program to one that principally provides direct health care services, it is recommended further:

That the CHR line item within the IHS budget be shifted from the IHS budget "Preventive Health" category to the "Clinical Services" category and that the CHR budget line item status be maintained.

**DEVELOPMENT OF RECOMMENDATIONS FOR DATA COLLECTION FOR CHR PROGRAM
REVIEW AND CONGRESSIONAL REQUEST AND INQUIRIES**

The CHR Program has been criticized as not being accountable and not complying with reporting requirements. The CHR Task Force has addressed these issues and recommends that reporting requirements be brought into compliance, and that further efforts be made to improve the reporting system to bring about program accountability.

It is recommended:

1. That there be a uniform mandatory reporting system for all programs, and that a clause in each contract be included mandating its use. That the data collection system be designed in such a way that information stored and used will be reflective of program accountability.

It is further recommended that a group (consisting of (1) Tom Bonifield, (2) Tanya Parker, (3) Ada White, President of the National CHR Association, and (4) a Tribal representative) be convened by January 15, 1983, to develop and/or adapt a data system that will provide information for the justification and allocation of CHR program resources at the national level. The system should receive appropriate review and comment by CHR's before implementation.

2. It is recommended that the IHS CHR Manual contain specific reporting requirements.

3. It is recommended that CHR reporting requirements must be specified in each contract and that the contractors be held in compliance with these requirements.

4. It is recommended that the National CHR Coordinator or Director at IHS Headquarters be assigned responsibilities for data collection.

5. It is recommended that data collection from other program activities which has already been collected by IHS be used by inference when appropriate to credit the CHR's.

6. The accountability of the CHR program has been limited due to lack of and use of an adequate reporting system on a nationwide basis. An adequate reporting system for all CHR programs is crucial because of the great variance among CHR programs. As an absolute minimum, the reporting system should produce accumulative data on each CHR activity by specific health care delivery function and area. This method will produce the accountability of the CHR program and still retain the program's flexibility at the Tribal level. Hard statistical data of this nature has never been utilized in justification of the program.

7. It is recommended that IHS explore analyzing statistics in terms of declines in mortality and morbidity that have occurred since the CHR programs began, particularly tuberculosis and infant mortality.

8. It is recommended that data collected by IHS be distributed back to the Tribes for their use and that IHS be responsible for providing meaningful interpretation of this data.

**RECOMMENDATIONS ADDED AT THE FINAL CHR TASK FORCE MEETING IN PHOENIX,
ARIZONA**

The National CHR Task Force Recommended:

1. That no more than 15 percent of CHR program resources be expended for administrative cost, both direct and indirect. Funding of direct administrative costs should have priority over indirect cost. Allowable administrative cost in excess of 15 percent should be secured from funding sources other than CHR program resources.

2. That an evaluation of the CHR program should be conducted in a manner that allows for measurement of its medical efficacy and cost effectiveness on a health care delivery function and area specific basis.

3. That the FY 1983 CHR contract and grant scopes of work be developed consistent with the health care delivery functions, areas, and settings as defined in the Assessment of Indian and Alaska Native CHR Program Resource Distribution's first report. All CHR program contract and grant scopes of work should be monitored to assure compliance with this recommendation.

4. That the second phase of the IHS/CHR program assessment project as described in the project summary dated April 25, 1982, be conducted as soon as possible. The second phase of the project will include a review of all 234 CHR program contracts with the primary objective of determining those health care

delivery functions and areas to which they relate. It is expected that the base information gained through this phase of the assessment will be valuable in the future management and direction of the CHR program.

CLOSEOUT SESSION

The joint meeting of CHR Task Force members and CHR Association Representatives held their final work session November 4th. The group's morning activities consisted of completing and finalizing of the recommendations to be submitted to the Director, IHS. We were pleased to have Dr. Everett Rhoades, Director, IHS, attend a portion of the morning meeting to address the groups in this closeout session. Dr. Rhoades commented on the overall IHS program budget projections for FY 1983, including some of the critical health care delivery issues that the IHS and Tribal governments are currently experiencing. Dr. Rhoades discussed CHR effectiveness in providing essential health care services. Dr. Rhoades also stated that demonstrated effectiveness, accountability, and creditability will continue to be crucial elements for program justification and continuation.

Dr. Rhoades concluded by expressing his thanks to the Task Force and the Area participants for the work they are doing and stated that he would be looking forward to receiving the final report.

The two groups spent the rest of the morning completing the recommendations for the final report. The meeting was adjourned with a prayer given by Priscilla Webb.

ELEVATION OF THE POSITION OF THE DIRECTOR OF THE INDIAN HEALTH SERVICE TO THE LEVEL OF AN ASSISTANT SECRETARY IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The notion of elevating the status of Indian Health within the Department of Health and Human Services is not new. It was suggested by the now Director of the Indian Health Service back in 1975 and 1976.

The benefits of such an arrangement would be:

1. Better coordination of all services rendered to Indian people by the Department of Health and Human Services.
2. Administrative white tape that currently overburdens the relationships in the Department can be eliminated (HRSA, PHS, etc.).
3. The multitude of resources that the Department has could be brought to the aid of and coordination of health services for Indians thus relieving Congressional Committees of inefficient activity resulting from that lack of coordination.
4. A comprehensive health benefits package could be constructed for Indian people by the Department that would cross several areas and be funded by several different sections of the Department (NIAAA, NIODA, HICFA, etc.) creating efficiency and effectiveness in the Department in dealing with the status of Indian health.

In short, the total resources of the Department should be brought to bear on the problems of Indian Health Service. This does not seem possible unless the Indian Health Service is high enough in the Department to coerce this kind of cooperation needed to help Indian people elevate their health status.

It is recommended that Congress commission a General Accounting Office study to determine the feasibility of a plan to elevate the status of the Indian Health Service within the Department.

THE IMPACT OF COMPETITIVE BIDDING ON THE QUALITY OF AND ACCESS TO HEALTH CARE IN THE ABERDEEN AREA

The quality of and access to health services will be seriously compromised in the Aberdeen Area if competitive bidding requirements are fully implemented.

The concept that all services are the same as far as quality and acceptability would go against historical referral patterns and be contrary to physician preferences for tertiary care, impairing relationships with colleagues with whom they are familiar and with whom Indian people have established a continuity of care relationship. This would inevitably result in a lesser quality of care for Indian people.

The use of competitive bidding process should be left to the Area Chief Medical Officer, whereby he or she can exercise judgment regarding the issues of quality, access, acceptability, etc.

This would allow for the negotiation of contracts that result in the stabilization of quality, of referral patterns, if continuity of care and confidence in the IHS system. That is, specialists would be seeing the same client on a continuing basis. This is certainly the most desirable situation from both the provider and client perspectives.

Other non-quality issues that would become problems are: the cost of travel to care is becoming prohibitive, the use of generic supplies to decrease cost (also decrease patient acceptance), the lack of patient compliance (patients not keeping appointments) resulting in increased cost due to complications, and the general decline in the ability of the IHS system to meet patient acute care needs due to a demise in current patterns and relationships which support a preventive family care oriented system.

PROBLEMS RELATED TO PUBLIC LAW 93-638

The contracting of programs to Tribes under Public Law 93-638 is increasing immensely in the Aberdeen Area. With the increase in contracting, the following problems are coming to the forefront:

1. There is inadequate indirect cost money to support the contracts and grants with Tribal governments. This results in the reduction of services because the indirect cost must then come from the Hospitals and Clinics account or other services accounts.

The other alternative is not supporting the normal cost of Tribal government by not allowing or convincing Tribal government not to accept indirect costs.

2. The programs Tribes are accepting are poorly funded, sometimes less than 50 percent funded.

3. The requiring of Tribes to adhere to strict cost accounting methods and budget activities is contrary to the flexibility needed to operate health programs. This flexibility exists in the Indian Health system because of its size and the ability to transfer funds from one Service Unit to another. Flexibility also exists after the year end in that funds can be deobligated and used to satisfy any claims, not just those claims in a certain budget activity.

These problems are not insurmountable, but need attention to facilitate the turning of programs over to Tribes. Some alternatives are:

1. The appropriating of funds to support the normal cost of contracting with Tribes. This would serve as an inducement to Tribes to contract and manage their own programs. The Aberdeen Area requires about \$1,500,000 in additional Tribal Management funds to support the contracting process.

2. Attention must be given to supporting the Indian Health Service base program. The base program has been eroded by inflation and now requires additional support to keep pace with needs and demands placed on it by constituents. Tribes will not and should not be allowed to accept programs that are doomed for failure because of inadequate resources.

3. Certification of the Public Law 93-638 regulations is necessary to allow for necessary flexibility and creativity in program management and development. That is, Tribes after proper request should be allowed to use funds from one budget subactivity for another as long as they are fully meeting the program requirements set out in the contract for the budget subactivity from which funds are transferred.

EXISTING INADEQUACIES IN HEALTH PERSONNEL, EQUIPMENT, AND/OR FACILITIES

The Aberdeen Area has a multitude of inadequacies when compared to accepted staffing methodologies for health care systems, the Joint Commission on Accreditation of Hospitals standards, and Health Care Financing, Medicare/Medicaid standards.

Attached are approved plans for correcting those inadequacies.

The barriers to accomplishing the aforementioned are:

1. Inadequate financial resources.
2. Inadequate full-time employment levels, i.e., ceiling.

3. Inability to utilize fully Medicare/Medicaid collections (Aberdeen Area collections were offset by \$739,000 in Fiscal Year 1983) to correct deficiencies.

4. Inappropriate appointment mechanisms for temporary positions, i.e., the restrictions on the use of term appointments to promote retention and recruitment.

5. Automatic data processing restrictions stifling systems development and creative efforts to facilitate efficiency and effectiveness in delivering health care.

The actions recommended for elimination of the above barriers are:

1. The restoration of full-time employment levels, pay raise and supplemental request, and the development of a budgeting process that will provide for cost of living increases commensurate with the private sector, i.e., accepted industry inflation figures.

2. The elimination of employment ceilings throughout the Indian Health Service.

3. That a Congressional mandate to cease and desist the offsetting of third-party collections be issued this year and be made a continuing instruction to the Department in further appropriation Acts.

4. Action taken to make the use of term appointments be made commonplace within the Indian Health Service to facilitate recruitment and retention.

5. That a model Service Unit (in the Aberdeen Area) be identified for the development of an automated health system (Medical Records, Supply, Financial Management, Payroll, Timekeeping, Patient Monitoring, Lab, X-Ray, Communications, Facility Monitoring, etc.). After the model is workable that it be replicated throughout Indian Health Service Hospitals.

UNMET NEEDS FOR WATER AND SANITATION FACILITIES

The construction of water and sanitation facilities is perhaps the most important link to continued improvement in the health status of American Indians.

The program to continue this progress, however, must be adequately supported in three areas—construction, operations, and maintenance.

Attached is a self-explanatory summary of those construction Unmet needs for the Aberdeen Area.

The construction of these facilities will serve to decrease outpatient visits and inpatient days for Diseases of the Respiratory System, Diseases of the Skin and Subcutaneous Tissue, Diseases of the Digestive System, to name a few. These are four of the top ten outpatient visit diagnoses and five of the top ten causes for admission to hospital that could be minimized by adequate water and sanitary facilities. This means that those resources currently being used for this kind of care can be diverted to other conditions thus having a domino effect on improving the status of Indian health.

SANITATION FACILITIES CONSTRUCTION SERVICES

The Sanitation Facilities Construction program as authorized by Public Law 86-121 constructs sanitation facilities for Indian homes and communities within the Aberdeen Area. Between 1960 and 1982 a total of \$63,682,175 involving 299 projects has been allocated the Aberdeen Area for this purpose. The construction has provided water and/or sewer first service to a total of 12,425 homes. An additional 5,574 homes received upgraded facilities or improvements to facilities which were already existing at the time of the project construction. Community facilities conforming to applicable engineering standards and the special needs of the reservations have been constructed in virtually every significant grouping of homes within the Area.

Yet despite the significant construction accomplishments, considerable facilities remain to be provided for the health needs of the Indian people. In 1982, 11 requests for assistance were received from the Tribes. The BIA fiscal year 1982 consolidated housing inventory shows 1,692 housing units in substandard condition, a need for 2,112 new homes, and a need for 667 housing unit renovations. Needed sanitation facilities for these homes normally should be provided under Public Law 86-121—Housing funds.

The Area has currently identified Unmet needs for Public Law 86-121—Regular projects (existing homes, capital improvements, solid waste, etc.) totaling \$25,216,000. This will represent first service to 649 homes and provide communities with system capital improvements, establish solid waste systems, etc. Except for two special Congressional appropriations (Standing Rock—fiscal year 1979 and Turtle Mountain—fiscal year 1980) no regular Public Law 86-121 funds have been received since fiscal year 1977.

The third category for Public Law 86-121 is for special or emergency projects. Except for one project at Pine Ridge, no funds have been received by the Area for these type of situations since fiscal year 1978. Although obviously emergencies cannot be predicted, it would seem unlikely that additional requests for assistance will not be received.

The Sanitation Facilities program is a co-operative program with the Indian Tribes. Since 1961, the individual Tribes and others have contributed \$3,768,237 toward the construction of their facilities. Tribal governments, organizations, and individuals are continually involved in the development and construction of the projects. In fiscal year 1982, construction by the Tribes or Indian contractors amounted to \$537,750 of the total \$1,020,079 constructed awarded.

UNMET NEEDS PRIORITY LIST
ABERDEEN AREA

PRI	SFCODE	ORIGID	SFNANE / ORGNANE	PH WATER SEWER SOLID URM	COST	CUMULATIVE COST
059	46	1014S	LOWER BRULE UTILITIES COMMISS		90,000	
069	46	1021YK	YAKTON SIOUX UTILITY COMMISS		20,000	
016	4603IAA	1016RS	VEBLER DISTRICT CENTER	01 B F A	79,000	
04S	460330	1017LT	ST FRANCIS	01 B F A	100,000	
073	460341	1017LT	VEBLER FLATS	01 B F A	79,000	
098	460357	1017LT	NAUBAY	01 B F A	380,000	
012	46036E		INDIVIDUAL SCATTERED	01 A E B	260,000	
054	46037E		INDIVIDUAL SCATTERED	01 A E A	900,000	
033	46125E	1015PR	PIKE RIDGE SCATTERED	01 AB F AS	1,084,000	
002	46151E		INDIVIDUAL SCATTERED	01 A EF A E	5,498,000	
011	46176E	1017LT	LAKE TRAVERSE SCATTERED	01 A E A EF	370,000	
018	46212E		INDIVIDUAL SCATTERED	01 A A A	270,000	
028	46225E	1012CR	BEAR CREEK	01 A A A	170,000	
025	46227E	1012CR	SAFFRIDGE/ROCKSVILLE	01 A A A	50,000	
023	46251E	1012CR	WHITE HORSE	01 A A A	8,000	
047	4635231	1012CR	IDEAL	01 A A A	50,000	
090	4639311	1012CR	PAIDEN	01 A A A	30,000	
034	4639311	1012CR	ROBERT CREEK	01 A A A	3,000	
034	4639311	1012CR	WINTER HAD ROUSING	01 A A A	60,000	
021	4639311	1012CR	RED SCATTERED COMMUNITY	01 A A A	84,000	
031	4639311	1012CR	GRASS MOUNTAIN	01 A A A	800,000	
021	4639311	1012CR	GRASS CREEK HIGH SCHOOL	01 A A A	214,000	
039	4639311	1012CR	RED BEAR	01 A A A	430,000	
037	4639311	1012CR	GRASS CREEK HIGH SCHOOL	01 A A A	250,000	
079	4639311	1012CR	GRASS CREEK HIGH SCHOOL	01 A A A	300,000	
035	4639311	1012CR	GRASS CREEK VILLAGE	01 A A A	250,000	
032	4639311	1012CR	FORT THOMPSON	01 A A A	250,000	
034	4639311	1012CR	LOWER BULL COMMUNITY	01 A A A	300,000	
062	4639311	1012CR	LITTLE EAGLE	01 A A A	400,000	

Above Minimal, Individual System, First Time Serviced
 Above Minimal, Community System, First Time Serviced
 Minimal, Individual System, First Time Serviced
 Minimal, Community System, First Time Serviced
 Above Minimal, Individual System, Previously Serviced
 Above Minimal, Community System, Previously Serviced
 Operation and Maintenance Organization
 Minimal, Individual System, Previously Serviced
 Minimal, Community System, Previously Serviced

SHEET SEWER PRIORITY LIST

ABERDEEN AREA

PRI	SF CODE	ORIG	SPARE / ORIG	PH WATER SEWER SOLID	QAM	COST	CUMULATIVE COST
003	10	10335F	SAC-FOX SETTLEMENT QAM			\$10,000	
004	31	10715N	SANTEE UTILITIES COMMISSION			25,000	
005	31	10700N	MACY COMMUNITY SYSTEM			21,000	
006	31	10222N	MINNEBAGO COMMUNITY SYSTEM			20,000	
010	3100003	10335F	SAC-FOX SETTLEMENT	01 A	P	1,015,000	
003	3100004	10715A	SANTEE	01 A	E	86,000	
024	31227AE		INDIVIDUAL SCATTERED	01 A	EF	199,000	
017	31221RE		INDIVIDUAL SCATTERED	01 A	E	188,000	
027	38	10187M	TURTLE MT PUBLIC UTIL CORP			20,000	
062	38	10185N	STANJOIN ROCK WATER & SEWER			25,000	
016	33	10287M	TRENTON WATER USERS ASSOC			10,000	
055	33	10137T	W.S. LK SR WTR & SWR USRS ASS			10,000	
057	33	10129B	FT BERTHOLD UTILITIES COMMISS			10,000	
023	3522948	10397M	TRENTON	01	P	115,000	
022	352243E		INDIVIDUAL SCATTERED	01	P	3,500,000	
027	35259E		INDIVIDUAL SCATTERED	01	A	225,000	
019	35189E		INDIVIDUAL SCATTERED	01	A	475,000	
013	35199E		INDIVIDUAL SCATTERED	01	AD	2,931,000	
042	3532205	10178H	WHITE SHIELD	01	P	1,250,000	
014	3532207	10158H	FOOT VALLEY	01	P	100,000	
033	3532208	10158H	CANONDAUA	01	P	350,000	
027	3532311	10137T	FT TOTTER	01	P	136,000	
026	3532315	101278	FOUR BEARS	01	P	500,000	
045	3590021	101278	MAUDAREE	01	P	140,000	
070	46	10117L	FLANDREAU SANTEE SIOUX TRIBE	01	P	100,000	
071	46	1010CR	CHEYENNE RIVER SAN LANDFILL			4,000	
072	46	10099C	LAKOTA SANITARY DISTRICT			11,000	
050	46	1014CC	OUGH CREEK UTILIT & MAINTENANCE			1,000	
038	46	1017LT	LAKE TRAVERSE UTILITY COMMISS			10,000	

Above Minimal, Individual System, First Time Served
 Above Minimal, Community System, First Time Served
 Minimal, Individual System, First Time Served
 Minimal, Community System, First Time Served
 Above Minimal, Individual System, Previously Served
 Above Minimal, Community System, Previously Served
 Operation and Maintenance Organization
 Minimal, Individual System, Previously Served
 Minimal, Community System, Previously Served

UNIT NEEDS PRIORITY LIST
AMERSEN AREA

PRI	SF CODE	ORG ID	SF NAME / ORG NAME	PH	WATER	SEWER	SOLID	ORG	COST	CUMULATIVE COST
013	4590457	1013T	LONG HOLLOCH	01					20,000	
049	4590465	1011FL	FLANDREAU MID SCH	01	DE				35,000	
043	4590471	1015PR	WAGBLEE	01	F				35,000	
003	4590474	1015PR	KYLE	01	F				100,000	
030	4590475	1015PR	PINE RIDGE VILLAGE	01	F				100,000	
031	4590480	1015PR	OGALA	01	B	F	A		400,000	
043	4590481	1015PR	ALLEN	01	F				20,000	
049	4590494	1015PR	WASPANI	01	F				125,000	
021	4590495	1016SR	PARSLLEE	01	F				80,000	
033	4590493	1016SR	OKREEK	01	F				80,000	
031	4590494	1016SR	ROSEBUD	01	F				144,000	
044	4590498	1016SR	MILKS CAMP	01	F				113,000	
074	4590499	1016SR	ST FRANCIS MID HOUSING	01	F				100,000	
036	4590510	1016SR	WASPALA/CHIEF SAUL INN	01	F				205,000	
041	4590513	1016SR	UPPER CUT MEAT	01	F				150,000	
015	4590518	1014CC	BAD MATION	01	F				\$25,216,000	
74									0	

Above Minimal, Individual System, First Time Served A
 Above Minimal, Community System, First Time Served B
 Minimal, Individual System, First Time Served C
 Minimal, Community System, First Time Served D
 Above Minimal, Individual System, Previously Served E
 Above Minimal, Community System, Previously Served F
 Operation and Maintenance Organization G
 Minimal, Individual System, Previously Served H
 Minimal, Community System, Previously Served I

Senator ANDREWS. Our next witness is Mr. Russell Hawkins, the chairman of the Sisseton-Wahpeton Sioux Tribe.

Do you have a prepared statement?

Mr. HAWKINS. Yes, I do.

Senator ANDREWS. We will see that it is made a part of the hearing record.

STATEMENT OF RUSSELL HAWKINS, CHAIRMAN, SISSETON-WAHPETON SIOUX TRIBE

Mr. HAWKINS. I have submitted 20 copies and I have the original here. It is a 40-page document.

I want to start out by saying it is a great honor and privilege to be here. I am chairman of the Sisseton-Wahpeton Sioux Tribe. I am representing our tribe. We have a statement which is approximately 40 pages long and I will not go into detail on that statement simply because I trust you or your staff will read it and I don't want to take your valuable time by being redundant.

I can tell you the four areas of contention within our statement are relevant to the reauthorization of the Indian Health Care Improvement Act, the budget cuts and threats of budget cuts, and responses made. Some of the recommendations of the contract health care services task force report we agreed with, some we disagreed with. Last, but not least, we are addressing the problems of 638 in various components and as I stated, I trust this will be read and so I will not waste your time now.

Senator ANDREWS. It certainly will be. That is what we are out here for; to collect the information.

Mr. HAWKINS. OK. I will not go through all 40 pages.

What I would like to talk about is related to health care and I would like to paint a little scenario for you and show you some of the needs and repercussions when our health needs are not met on the reservation.

One area, in particular, that we are in need of are orthodontists. We have people with teeth problems and while this sounds somewhat minor at first, what happens is Indian kids in the public schools are generally shy. We do not have the economic background. We do not have the social status of our non-Indian counterparts and so as a result we are much more shy and withdrawn in the public school systems. When this problem is compounded by having problems with our teeth and speech, it inhibits us and makes it much more difficult for us to participate in the English, the place, the drama, and within the high school extracurricular activities. As a result, we do not feel part of the system and when we do not feel part of the system we start having a negative self-image. The negative self-image results in lack of achievement in the academic atmosphere and of course as time goes on school becomes negative, delinquencies increase. We have a high rate of dropouts, and with the dropouts we have kids on the street not able to work because of lack of skill, lack of jobs, but also they are not yet 18.

Then we have the spinoff of crime. We have delinquency. We have kids getting into trouble. They need money.

With that we go into the courts. With that we are generally found guilty and we have, of course, more than our share of inmates in the penitentiary, and inmates in a penitentiary do not help. They are not paying taxes. They are not helping the country. So, we have a lot of serious spinoffs and negative repercussions of what could have been prevented with adequate health care at an earlier stage.

The same can be said for optometrists. We have many kids again that need eyeglasses, many elderly people need eyeglasses and a lot of the young kids do not know they have poor vision and there are not the financial resources to insure the adequate checking and the prescription of the necessary eyeglasses.

Again, we have the repeat of the situation. The kids cannot read what is being taught and if you cannot read, whether you have a math problem, whether you have a history problem, whether you have an English problem, a spelling problem, if you cannot read it, you cannot do any of it.

The dropout rates are exorbitantly high with Indian kids and we do not think it is the teachers being callous and not caring but we think that there are very physical and real reasons that this occurs. Of course, with adequate funding, we can cure many other spinoff problems from this, whether it is being self-conscious because your teeth are crooked or missing or whether it is the inability to see what is on the blackboard.

So these are some areas that have negative repercussions in a seemingly unrelated area such as Indian health. But that is just one scenario I wanted to paint simply because it is something that I am aware of.

I am aware of this and I see it with the schools and it is hard to put the finger on the problem to address all the needs, but this is certainly a part and a contributing factor to the Indian health problems we do have.

Senator ANDREWS. What you are saying is sometimes it is cheaper to run these programs, spend the money on the programs than to pay for troubles you get if you do not have the program.

Mr. HAWKINS. Absolutely, yes. That was basically my statement.

I do want to just briefly conclude by stating that I have heard many good things about you. I know that you are an advocate in many areas and I want to illustrate the other side of the coin. For instance, the Sisseton-Wahpeton Tribe extends into North Dakota and parts of South Dakota and our tribal members, of course, have supported this country when this country needed it in terms of war and in terms of doing their duty for their country.

I am proud to say that my stepfather is a fullblood Sisseton-Wahpeton Sioux from North Dakota. When World War II broke out he volunteered. He fought at Guadalcanal. He later fought in Korea. He received the Distinguished Service Cross and he was North Dakota's most decorated soldier. He just passed away with a list of illnesses as long as this table. He passed away last January.

Many of our people volunteer quickly in time of war to help this country and if you check with the Army Board of Awards and Decorations, they have a lot of statistics to show that for Indians the patriotic duty is there above and beyond the call of duty and I would en-

courage you to bear this in mind when you are talking about authorization and appropriations of funding and when you are talking about helping Indians. Now, let us not forget who helped when the Government needed it, too.

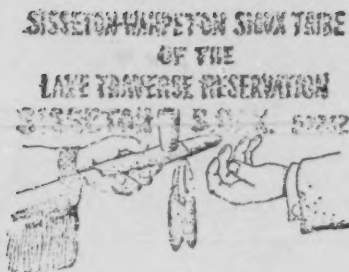
Senator ANDREWS. No, we cannot, because your people have an outstanding record of service to this country and you certainly have an outstanding contribution to this heritage and to today's economic viability. Good day, Mr. Hawkins.

Mr. HAWKINS. Incidentally, my stepfather's name is Woodrow Keeble.

Senator ANDREWS. I think it would be great to mention him, being as close as we are to Memorial Day.

Mr. HAWKINS. Thank you for your time.

[The prepared statement follows. Testimony resumes on p. 242.]



June 2, 1983

Senator Mark Andrews, Chairman
 Senate Select Committee on Indian Affairs
 United States Senate
 6317 Dirksen Senate Office Building
 Washington, D.C. 20510

Dear Chairman Andrews and Members of the Committee:

Thank you for this opportunity to present testimony in behalf of Sisseton-Wahpeton Sioux Tribal Government on INDIAN HEALTH CARE ISSUES that affect the lives of Indian people on the Lake Traverse Reservation. The Tribe submits that, inasmuch as adequate appropriations have never been supplied so as to realize the intent of the Indian Health Care Improvement Act to raise the health status of the American Indian to a level commensurate with that of the overall population of this Country, REAUTHORIZATION of the INDIAN HEALTH CARE IMPROVEMENT ACT (as well as the appropriations needed to effect its implementation) IS NECESSARY. To the contrary, the Indian Health Service is facing net value cutbacks in appropriations, resulting in DIMINISHED (and fears of diminished) SERVICES. The Tribe views the activity of the National Contract Health Service Task Force as one (of many such) initiatives to ERODE THE AVAILABILITY AND ACCESSIBILITY of health care to Indian people. Nor does the Indian Self-Determination and Educational Assistance Act represent the anticipated means to resolve problems pertaining to health on the Reservations, because FINANCIAL SECURITY OF THE TRIBALLY-CONTRACTED, "638" PROGRAMS IS LACKING. The Tribe's experi-

ence is that the Tribal contracts are the first to be cut and are funded at a lower level than the amount which was available when the Federal Agency operated them. There are, then, Indian health care issues which warrant continued Congressional attention and greater Congressional support, as is supported by the following, additional discussion.

1. REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT IS NECESSARY TO ADDRESS "UNMET" HEALTH NEEDS:

This Tribe is mindful that within the last decade the U.S. Congress enacted two pieces of legislation, the Indian Self-Determination and Educational Assistance Act (P.L. 93-638) and the Indian Health Care Improvement Act (P.L. 94-437), which were intended to provide opportunities for Tribes to upgrade the human services programs designed for their benefit. Pursuant to the Indian Health Care Improvement Act, this Tribe (and all other Tribes in this Nation) went through the painstaking and extensive effort of identifying its unmet health care delivery needs via a Tribal Specific Health Plan. In the National Plan that was compiled upon completion of all the Tribal Specific Health Plans, the Secretary of Health, Education and Welfare projected that the total additional resources needed in order to bring the Indian health care delivery system up to par would be 12,365 staff and \$2,849,301,000. The National Plan, therefore, confirmed the fact that the Indian Health Service is grossly underfunded to fulfill its responsibilities to Indian patients. Yet, despite all this documentation, in its next breath the Congress, in efforts to balance the Federal Budget and to reduce all Government spending, presses to instead cut funding for the Indian health programs. From the Tribe's perspective, there is concern that Indian health care appears to be severely COMPROMISED by the whims of politics -- which is an insult and an injustice to Indian people. The very intent of P.L. 93-638 and P.L. 94-437 are so undermined and eroded by the lack of dollars made

available to implement them as to render them impotent.

For example, the Act acknowledged that lack of qualified INDIAN HEALTH MANPOWER is one critical issue and authorized the provision of preparation and scholarship support to students entering the medical/health field. The Indian Health Service has a very difficult time recruiting and retaining doctors, nurses, technicians, and other professional staff. The Reservation environment has not stimulated and consistently supported young people pursuing educational goals. Satisfactory incentives for Indian students to enter health career fields have not been developed. Also adequate funding, made available on a timely basis, has not existed. (How many Indian students have been forced to drop out of school because of financial insecurity?) Finally, Indian Health Service and Tribes have not approached the manpower shortage with a realistic plan. No effort has been made to develop the potential of Tribal members right in their jobs, although it is self-evident that only persons with roots and ties in the Indian community are going to remain there.

The Tribe maintains that the first and critical step in breaking the cycle of problems that does exist on the reservations is to recruit Indian people into health career training programs and support their participation in them. It is believed that Tribal members, once they are equipped with the appropriate technical, problem-solving, and management skills, will be the ones to provide services in a manner consistent with Sisseton-Wahpeton Sioux priorities and policies so that the root problems will be impacted. Only through Tribal control, or Indian self-determination (if you will), can basic self-sufficiency and dignity of Indian families be restored and sustained.

However, the Indian student is handicapped in his/her endeavor to pursue Higher Education by obstacles and problems which most other students do not have to deal with. These obstacles include the following:

- A. Financial aid for tuition, educational supplies, and room and board is not provided in a timely manner by the Bureau of Indian Affairs and other

entities responsible for administering education funds intended for Indian students. Without the means to sustain themselves, the student has no alternative but to drop out.

- B. There is a lack of family support for the Indian student pursuing higher education. Indian families have few financial resources to commit to educating their members. In addition, some families do little to motivate or encourage students. In fact, the tendency is for families to pull the student home, back to the Reservation, where they can participate in the concerns and activities of the family. The Education Ethic, which is apparent in non-Indian society, does not have the same validity and importance in Indian culture. In fact, the educated Indian is often met with skepticism, suspicion, and ridicule and is compelled to demonstrate that (s)he remains "Indian" after indoctrination in the white man's ways. It takes special drive, determination and commitment for the Indian student to overcome this obstacle.
- C. Many Indian students have dependents to support: children, parents, siblings, and extended families. Their time, efforts, and finances are committed to this objective. The Indian student with a family has an especially hard time making ends meet.
- D. Indian students often find themselves inadequately prepared -- scholastically and culturally -- to function successfully in an academic setting. Being of an ethnic minority with a unique value system and way of perceiving the world (thus looking different and acting different) puts the student at a disadvantage in the first place. The problem is compounded when the student discovers that (s)he has not been equipped with the skills required to complete coursework successfully.

Time and time again, Indian students give up and return to the Reservation feeling frustrated -- and that they have failed and been defeated by "the System". "What's the use?" they ask. "Who cares? I can't make it."

Incentives and support such as the INDIANS IN MEDICINE PROGRAM offered at the University of North Dakota, which strives to get Indian people to participate in higher education in general and (especially) in health career training, then, are needed. First, there is need to create interest and awareness in health careers and advertise the professional and financial benefits involved. Secondly, the Tribe needs to support and encourage upward mobility and training of Tribal members through commitment and mobilization of resources in their behalf. Finally, the Tribe needs to inspire those who have received training to return to the Reservation and apply their skills to serve other

Tribal members.

Funding for programs, then, such as INDIANS IN MEDICINE and the scholarship programs is very much needed. It is TRAGIC that the funding for these programs has been reduced and that further cutbacks are threatened.

A second major issue in regard to the Indian Health Care Improvement Act is that its AUTHORIZATION to allow the Indian Health Service TO COLLECT THIRD-PARTY REIMBURSEMENTS FROM MEDICARE AND MEDICAID IS NOT A PANACEA. Yes, the funds collected thereby do supplement the operating revenues of the Indian Health Service. HOWEVER, it also subjects the Indian Health Service to Medicare/Medicaid certification standards and casts IHS in a different perspective: That of a "residual" resource, to be utilized only after services from other Government-funded programs have been sought and denied. The legislation authorized the Indian Health Service to collect third party payments for patients who are Medicare/Medicaid eligible as a supplementary funding mechanism but does not, however, stipulate that the monies collected should remain in the same Area and at the same Service Unit which collected them. This Tribe has been concerned that the Medicare/Medicaid monies collected at the Sisseton-Wahpeton Service Unit and by the Aberdeen Area, overall, have been submitted to IHS Headquarters and, from there, were largely redistributed to other Areas which did not collect them as actively. This lessens the incentive for Service Units to collect them. Per Tribal Council Resolution 82-94, this Tribe is on record to petition that the authority of the Indian Health Service to collect third party payments should be extended TO INCLUDE PRIVATE HEALTH INSURANCE AND THAT ALL REVENUES RAISED THEREBY BE MANAGED AND UTILIZED AT THE SERVICE UNITS WHICH COLLECTS THEM. However, the Tribe is also concerned that the level of Federal appropriations should not be reduced because of the third party reimbursement revenues available. It is feared that the third party payments are already beginning to jeopardize the IHS

Budget, as they are discussed so extensively in the FY/84 Justification of Appropriation Estimates for Committee on Appropriations -- Indian Health.

We are not at this time going to provide elaborate comment on the HEALTH STATUS OF INDIAN PEOPLE AS COMPARED TO NON-INDIANS, inasmuch as ample documentation and statistics are available to Congress already in the form of the Tribal Specific Health Plans which were submitted to the Congress in 1979 and which were, again, updated in 1981. Ample information is there. There has been excessive talk about raising the status of the Indian Health Care Delivery System but the followup is lacking. Excellent support of this point appeared in the May 23, 1983 editor's page of the U.S. News & World Report entitled "Goldwater Tees Off" by Marvin Stone. Writes Stone:

"... In a recent letter to President Reagan, Goldwater raised a ruckus. Here's some of the things bothering him: 'In over the 207 years that we have had a government, in well over a hundred years of our relationship with our Indians, we have never, I repeat, never, lived up to the moral obligations that we owe these people... I think we pay far more attention to the human rights of people living in the countries of South Africa, or Central America, or you name it, than we pay to the human rights of the Indians living within our States.' The senator then proceeded to cite what he called some 'shameful statistics' to show how the U.S. Government has mistreated Indians. Goldwater cited complaints of Indian Tribal leaders about the Government's 'inconsistency in Indian policy,' and about the federal agencies responsible for serving Indians. Recently, the senator said, 'Our Senate Select Committee on Indian Affairs staff has been informally advised that the Department of Health and Human Services no longer intends to engage in the construction of hospitals serving Indian people. As a matter of fact, the Indian Health Service has refused to release funds appropriated by the Congress in fiscal years 1982 and 1983 for the planning and design of hospitals...' Treatment of Indians, Goldwater told Reagan, is not just a question of human rights but also of 'moral obligations.' The Indian tribes, he said, live under agreements made with the U.S. government that 'have all the solemn obligations' of treaties with other countries. Then, in words that should strike a responsive note in the hearts of all Americans, Senator Goldwater told President Reagan: 'I am making this personal plea to you, Mr. President...because as a member of the United

States Senate, as an American citizen, who has lived most of his life with these Indians, I'm just plain fed up, sick and tired of the neglect of these people while at the same time you are asking us for millions, hundreds of millions, yes billions of dollars, to give to people scattered around this world to help in establishing human rights. Please, Mr. President, let's establish something in our own back yard that we can begin to be proud of before we wander around this earth trying to teach other people how to live and how to act toward each other. Let's act toward each other in this country like we really meanat what we talk about."

Senator Goldwater and Mr. Stone stated our position most eloquently, and the REAUTHORIZATION OF P.L. 94-437, AND APPROPRIATING THE FUNDS NECESSARY TO MAKE IT WORK, REPRESENT A CASE IN POINT.

2. BUDGET CUTS AND THREATS OF BUDGET CUTS JEOPARDIZE THE AVAILABILITY OF INDIAN HEALTH SERVICES AND COMPROMISE TREATMENT PROVIDED:

The Indian Health Service has been exploring and soliciting input from Tribes about how the Indian Health Service could continue to operate and fulfill its mission if its funding continues to DIMINISH. This issue is one which has been discussed extensively at the level of the Tribe's Human Services Board during this past year -- first in view of the IHS Reorganization Plan proposed last summer by the Aberdeen Area Director, and now again in consideration of the Indian Health Service Director's recent letter, which suggests prioritization of services and/or establishing rules of eligibility for defining the population to be served (i.e., by income, Indian blood quantum, residency, etc.) as cost reduction measures. Frankly, we were not sure whether we wanted to respond to the letter, lest by complying with the request for suggestions about what could be done if lack of funds became the bottom line, the Tribe might appear tacitly to concede that there should be reduced appropriations for Indian health care. To the contrary, the Tribe must first of all express its STRONG OPPOSITION TO THE CONCEPT OF DIMINISHED RESOURCES AND TO ANY PROPOSAL THAT WOULD REDUCE THE LEVEL OF SERVICES AVAILABLE TO INDIAN PEOPLE. Although the Tribe is in no way conceding to any proposal that there be cut-backs in Indian Health, we would like to share some of our thinking about what could be done if funding shortfalls should become reality. These thoughts are summarized as follows:

A. Retention of Medical Services ON THE RESERVATION Is Priority:

In response to the inadequate allocation and distribution of resources to the Aberdeen Area, the Indian Health Service Director had proposed a REORGANIZATION PLAN, intended to provide optimal level health care with available dollars by eliminating inpatient care facilities on some Reservations (i.e., Sisseton and Wagner) and arranging for services to be provided to patients from those localities at other units (i.e., Fort Yates and Pine Ridge). The Sisseton-Wagpeton Tribal Council is on record twice.

per Resolution Nos. 82-31 and 82-57, to oppose the Reorganization Plan and/or budgetary "reprogramming" that would result in lack of accessible, available, basic health care services right on the Reservation. It is thought that if the patients had a choice, they would choose to retain professional medical services and access to hospital care and perhaps give up some of the field health and outreach programs that currently exist, rather than face the option of being sent off to distant facilities for medical attention.

B. Establish One-Quarter Degree Indian Blood Quantum As a Condition for Eligibility:

Since 1921 when the United States Congress enacted the Snyder Act, funds have been appropriated annually to carry out the Government's fiduciary responsibilities to provide health care benefits to Native American people. Through the years the Government has established rules and regulations to govern the administration and delivery of health care services to Indians in Part 36, Title 42 of the Code of Federal Regulations, including Subpart A - "Purpose and Definitions," and Subpart B - "What Services Are Available and Who Is Eligible for Care?" However, the definition of Indian remains pretty open, as long as descendancy from an Indian ancestor can be demonstrated. The Congress has failed to appropriate funds for Indian health care commensurate with the growth in population of all persons who have Indian ancestry. Therefore, it would seem prudent that a cut-off point be established. Accordingly, this Tribe is on record per Tribal Council Resolution 82-93 that one-quarter degree Indian blood quantum as a condition for eligibility be imposed to close the population that the Indian Health Service is responsible for.

C. Alternatives Need To Be Considered That Would Not Eliminate or Reduce the Scope of Existing Services:

Via (enclosed) Resolution #82-94, the Tribal Council went on record to petition Congress to consider alternative plans to alleviate the financial plight of the Indian Health Service if no additional funds are to be appropriated, such as authorizing the Indian Health Service to collect third party payments from private health insurance carriers and, further, to allow the revenues raised thereby to be utilized at the Service Unit where it was collected. There is concern if Congress does not address the NEED for adequate funding for the Indian Health Service, health care on the Reservations will deteriorate.

D. More Contract Health Service Program Dollars Should Be Earmarked For Early Diagnostic Consultation and Prevention Care:

The inadequate appropriation of Contract Health Service dollars to the Indian Health Service has resulted in the tragic policy that the available funds be spent on Priority I. (emergency and life-threatening) medical conditions only. Per Tribal Council Resolution 82-42, the Tribe expressed its concern that under the present system of referring out crisis conditions only, Indian patients do not get good, preventive medical care. Treating a condition at the stage when it becomes emergent or potentially life-threatening is not logically a cost-effective approach. For example,

it is far less costly to treat a gall bladder problem before it becomes an emergency, or to send a patient out for diagnostic consultation so that the patient can receive appropriate followup treatment at an early stage, rather than to wait until the condition worsens and becomes more complicated, thereby requiring hospitalization and extensive, costly therapy. The present system of care, then, truly results in a hardship to patients, adversely affects their health, and, consequently, the quality and productivity of their lives.

The functioning of the tribally-operated COMMUNITY HEALTH REPRESENTATIVE (CHR) PROGRAM, is another program which has been HAMPERED by budget cuts and threats of budget cuts. During FY 1982 the CHR Program provided 5,890 home visits, 163 units of emergency services, 1,619 units of home health care (including physical therapy to invalid and convalescent patients), 5,157 units of transportation access during all conditions of weather, and 303 units of environmental health. The Tribe is very concerned, then, that the CHR Program may be eliminated if the FY 1984 Appropriations Plan submitted by the Reagan Administration is approved by Congress.

The CHR Program is very crucial to the health care of Indian people on the Reservation. The CHRs have had specialized training and are, therefore, qualified to make assessments during home visits made to convalescent, invalid, and elderly patients. The CHRs are able to spot many problems at an early stage and refer them to the attention of medical personnel, resulting not only in financial savings, but also (and more importantly) in reducing the pain and suffering of patients. A big factor in this is that the Indian people trust their CHRs and are better able to communicate with them than with busy doctors and nurses. The CHRs are able to take more time to listen, are more aware of the patient's history and home/family conditions, and share the same cultural frame of reference (including the ability to communicate in the Dakota Sioux language). The CHRs then, provide many prevention services.

Secondly, during these severe economic times (when the Reservation unemployment rate is in excess of 90%), many Indian people (particularly the elderly and women with small children) would have poor access to health care because they lack transportation were it not for the CHRs. The CHRs are the access to medical care for many.

A third consideration is that many Indian people live a long way from medical facilities. In times of emergencies and illnesses (especially during adverse weather conditions) the CHRs are often the first responders, the ones on the scene to provide direct care and to get the patients to medical care providers. Without the CHR Program, this vital link between Hospital and community would be missing. Other types of direct care provided by CHRs include physical therapy, homemaker services, checking blood-pressure, pulses, and temperatures, changing bandages, etc.

And finally, the CHRs provide community education and environmental health activities through one-to-one counselling, rabies clinics, and annual safety and community cleanup initiatives.

The CHR Program is the best prevention program there is on the Reservation. It is a viable extender of the Indian Health Service medical care program. Its discontinuation would leave a severe gap in the access Tribal members have to adequate health care services. Therefore, we request the Committee's support for its continuation.

Uncertainty about availability of TRIBAL CONTRACT SUPPORT FUNDS TO COVER INDIRECT COSTS MAINTAINING THE OPERATION OF CENTRAL TRIBAL ADMINISTRATION also affects the level of services available on the Reservation, because if the Indian Health Service cannot provide funds to cover indirect costs at the rate

established by the Office of the Inspector General, the Tribe is obligated (by the signed Indirect Cost Negotiation Agreement) to take the difference from the direct cost appropriation per se or from the Tribe's own funds! In the case of the Sisseton-Wahpeton Sioux Tribe, there are no independent funds to commit for this purpose.

The Alcoholism Programs, for example, are continuing to operate at the same level of funding as when they transferred from the National Institute of Alcohol and Alcohol Abuse (NIAAA). Yet the need for comprehensive and professional treatment services on the Reservations remains as one of the most serious unmet needs in Indian Country. To make matters worse, the Indian Health Service does not have monies in its Indirect Cost Pool to apply to these contracts. As a result, the Tribes are obliged to tap into the allocation itself in order to pay for the costs of administering the programs (thereby reducing the service dollars available). At our alcoholism program we are attempting to provide primary treatment of professional quality, but we are only able to offer our counselors salaries ranging from \$5.78 to \$4.00 per hour. It is difficult to recruit and retain staff that are effective with alcoholic clients and their families when the funds are not there to compensate them adequately. Additional funds, then, are required if Tribes are to combat the problems of alcoholism successfully.

It was only on May 31, 1983, that the Tribe received the long-awaited award of additional funds to cover the increase in the Indirect Cost Rate on its other Indian Health Service-funded programs. The availability of funds for this purpose was in question for eight months of the contract year, during which time the Tribe suffered severe cash flow problems. Services were limited because managers sought to hold their spending at a minimum in order to be able

to accommodate a reduction in direct costs, should they be forced to absorb the Indirect Costs which the Indian Health Service could not provide. Because of the layoffs and lapsed positions that the Tribe experienced because Indirect Costs have not been available for eight months, the level of accountability required by the Indian Health Service has not been maintained. Accordingly, the Tribe has been out of contract compliance several times, thereby again jeopardizing services available to Indian people if Indian Health Service had terminated the contract.

Within the spectrum also of services impacted by budget cuts is the lack of funds for WATER AND SEWER. Minimally, twenty-five (25) Reservation homes are in need of water and fourteen (14) others are in need of sewer systems. Thirty-nine (39) families total, then, are affected at an estimated cost of \$136,100.00. This funding request, along with the homes identified as in need and the location of these homes, has been provided to the Indian Health Service as of March 31, 1983.

The scope of effects caused by funding cuts in Indian Health care, then, have been both direct and indirect and are wide in scope.

3. RESPONSE TO RECOMMENDATIONS MADE BY THE CONTRACT HEALTH SERVICE TASK FORCE:

The Tribe has reviewed the Contract Health Service Task Force recommendations, the overt purpose of which is to improve the management efficiency of the Contract Health Service Program. However, the covert purpose of the Task Force appears consistent with the initiative to DIMINISH HEALTH SERVICES (which has been discussed extensively in the preceding section). The Tribe's reaction to the recommendations made is as follows:

- A. The Tribe agrees that the proposal to make the eligibility criteria for the Contract Health Service Program consistent with that of the Indian Health Service is feasible. The two sets of criteria currently followed can cause confusion.
- B. The Tribe does not agree that a patient should be a member of a Federally recognized Tribe in order to be eligible for care, as this plan would disqualify patients who do not have enough Indian blood from any one Indian Tribe to be enrolled, but who might have more Indian blood from various different Tribes than others who would be eligible. Secondly, the plan would subject the Indian Health Service to endless variation in Tribal criteria for enrollment, which would be confusing and unfair. Rather, the Sisseton-Wahpeton Sioux Tribe is on record per Tribal Council Resolution #82-93 that one quarter degree Indian blood quantum be the criteria employed if, indeed, one must be used to refine the definition of Indian.
- C. Similarly, the Tribe agrees that a geographical restriction could be imposed, limiting services to those that reside within the Contract Health Service delivery area only.
- D. The Tribe also agrees that patients should be enrolled in the Indian Health Service program under their Social Security number and should be issued a card that would provide them with access to care at other Indian Health Service facilities anywhere in the United States. The Contract Health Service dollars used for that patient's care would be those of the Area which treated the patient (rather than the Area the patient is from).
- E. The Tribe was interested in the Task Force's proposal that the priorities for Contract Health Service care should be reversed as follows:
 - 1) PREVENTIVE CARE - Family planning, pregnancy care, immunizations, hypertension, and tuberculosis
 - 2) BASIC PRIMARY SERVICES
 - 3) ACUTE CARE

However, the Tribe maintains that the Task Force's stipulation that all the Priority #1 cases would have to be addressed first before any cases in categories #2 or #3 could be dealt with is more absurd than the present priority system. What would become of the emergency and life-threatening condition patients while the Indian Health Service sought to deliver all the preventive services which are needed? Secondly, the Task Force's definition of Prevention differs from that of this Tribe (to whom the word means preventing the need for acute care). It is the Sisseton-Wahpeton Sioux Tribe's position, pursuant to Tribal Council Resolution #82-42, that MORE CONTRACT HEALTH SERVICE PROGRAM DOLLARS SHOULD BE APPROPRIATED AND THAT A PORTION SHOULD BE EARMARKED FOR EARLY DIAGNOSTIC AND PREVENTIVE CARE.

Another problem that the Tribe has with the Task Force recommendations is the proposal that the Indian Health Service Finance Office would no longer review and monitor the payment of Contract Health Service funds. Instead, the Medicare/Medicaid Program and/or private health insurance companies would do so. It is feared that the Indian Health Service (and the Service Units, specifically) would lose control over expenditures of their funds if this change came about. As it is now, the Indian Health Service medical and administrative staff review the bills that are submitted by Contract Health Service vendors very carefully to make sure that payment is not issued for treatment that was not authorized or that a misdiagnosis has not occurred. Secondly, the Tribe is concerned about the funds that Medicare/Medicaid or private health insurance companies would require in order to monitor payments. Would there be additional appropriations, or would the financing come off the top of existing allocations? The program would be drastically affected if administrative costs had to be absorbed. And the final question is, if the Government is willing to appropriate additional funds so that a non-Indian Health Service carrier can administer Contract Health Service Program payments in order to improve management efficiency, why not offer the same funding to the Indian Health Service per se, so as to adequately staff that agency to provide financial accountability in a more effective and efficient manner?

Overall, then, the Tribe recommends that the many adverse ramifications of the Contract Health Service Task Force be carefully considered and thoroughly discussed with Tribes before any steps are taken to implement them, as they will inevitably result in the elimination or reduction in scope of the Indian Health Service, as we know it today.

4. PROBLEMS RELATED TO THE "638" CONTRACTING PROCESS:

The Sisseton-Wahpeton Sioux Tribe has been very cautious about contracting functions from the IHS Service Unit because, according to Resource Allocation Document (R.A.C.) criteria, the level of funding and staffing is inadequate in the first place. Secondly, the Tribe's experience has been that the funding is DIMINISHED when a program is contracted from the Federal Agency.

An example is that of the Community Health Education Program, which is the only program the Tribe has contracted thus far from the Indian Health Service Unit. Before contracting the program it was determined that it was costing the Indian Health Service \$37,100.00 to operate it. The biggest portion of that amount was for salaries, as the overhead costs were absorbed by the Service Unit. Now that the Tribe has contracted it, the funding available is \$19,392 for Direct Costs and \$3,219.00 for Indirect Costs, totalling \$22,611.00. The funding level, then, is less for the Tribe to deliver the same service that the Indian Health Service previously provided. And even though the IHS Service Unit Director has allowed the program to move back into the building which formerly housed it (so as to avoid space costs), the program budget still can not accomodate a salary increase for the Health Educator (which would have been manditorily granted were the program administered by the Indian Health Service), nor are funds sufficient to procure educational materials which the program needs in order to be effective. If it were not for the fact that the present Health Educator (a college graduate) is very conscientious and motivated, it would appear that Indian patients had been SHORT-CHANGED by the Tribe's contracting of the program. The Health Education Program has been cut nationwide since the Tribe requested to contract the Health Education Program, and every Reservation received the cut. It is very unforunate that sufficient funding is not made available for Tribal contracts. The Tribe has had similar experience in contracting the Family/Child

Social Services function from the Bureau of Indian Affairs.

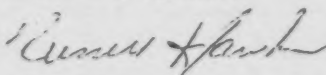
A second problem, which has already been discussed in Section 2. (on the impact of budget cuts and threats of budget cuts on Tribal Contract Support funds) is the uncertainty whether sufficient funds will be available to cover the Tribe's administrative costs at the Indirect Cost rate negotiated between the Tribe and the Office of the Inspector General, United States Department of the Interior. The Tribe can simply not afford to absorb the Indirect Costs for any program it operates from Tribal funds. And it does not have the cash flow to "float" the program, to retain professional administrators, or to maintain the level of accountability that the Indian Health Service requires for their contracts, if administrative (indirect) costs are not provided in a timely manner at the beginning of the fiscal year.

Overall, the Sisseton-Wahpeton Sioux Tribe has a very positive working relationship with the Indian Health Service. CONCERNS ABOUT FUNDING are the only "problems related to the '638' contracting process" which the Tribe has identified.

In fact, THE NEED FOR CONTINUED AND ADEQUATE APPROPRIATIONS IS THE COMMON DENOMINATOR on all the health issues raised in this Statement. Funding requirements, then, must be considered during the reauthorization of the Indian Health Care Improvement Act so that "unmet" health needs may be addressed. Funding is necessary if Indian patients are not to suffer adverse consequences relating to the availability and accessibility of medical care (such as the reduction/limitation of services which is currently being proposed by the Contract Health Service Task Force). And concerns about adequate funding is the major problem related to the 638 contracting process which has been identified. Until the need for additional funding is addressed, the problems identified in this Statement shall PERSIST.

Thank you for the opportunity to present the concerns of the Sisseton-Wahpeton Sioux Tribe on Indian health issues.

Respectfully Submitted,



Russell Hawkins, Chairman
SISSETON-WAHPETON SIOUX TRIBE

Enclosures

The Editor's Page

Goldwater Tees Off

By Marvin Stone



The plight of many of the Indians in the U.S. is told in the story that starts on page 70 of this week's issue. It is a disheartening problem, one that very few of us find time to address. One exception is Barry Goldwater.

When Senator Goldwater talks about Indians, he speaks from personal knowledge, because about one third of this country's 1.4 million Indians live in the Republican senator's home state, Arizona. In a recent letter to President Reagan, Goldwater raised a ruckus. Here are some of the things bothering him:

"In over the 207 years that we have had a government, in well over a hundred years of our relationship with our Indians, we have never, I repeat, never, lived up to the moral obligations that we owe these people. . . ."

"I think we pay far more attention to the human rights of people living in the countries of South Africa, or Central America, or you name it, than we pay to the human rights of Indians living within our states."

The senator then proceeded to cite what he called some "shameful statistics" to show how the U.S. government has mistreated Indians.

One example Senator Goldwater cited: The Papago Indian tribe, with 13,000 members and a reservation spread over 5,000 square miles, has only one hospital: "A number of years ago, this hospital burned down, and believe it or not, it took 10 years to reconstruct it," the senator told the President.

The Hopi Indians, according to Goldwater, have only one hospital, and "it's been reduced to being open only three days a week." He said that the Hopis lack adequate communications and transportation systems to reach patients with what medical aid is available. Also, he added, the Hopis have no high school, even though "there is money in the jobs bill to at least start a high school."

As for the Navajo Indians, Goldwater said: "The vast Navajo Reservation, the largest that we have, and the largest population of any Indian tribe, does not need any detailed de-

scription by me as to their lack of health and education facilities, decent roads running north and south, communications and on down the list. These people have the highest unemployment rate in the United States and suffer along with the other Indians."

Goldwater cited complaints of Indian tribal leaders about the government's "inconsistency in Indian policy," and about the federal agencies responsible for serving Indians.

Recently, the senator said, "Our Senate Select Committee on Indian Affairs staff has been informally advised that the Department of Health and Human Services no longer intends to engage in the construction of hospitals serving Indian people. As a matter of fact, the Indian Health Service has refused to release funds appropriated by the Congress in fiscal years 1982 and 1983 for the planning and design of hospitals. . . ."

Treatment of Indians, Goldwater told Reagan, is not just a question of human rights but also of "moral obligations." The Indian tribes, he said, live under agreements made with the U.S. government that "have all the solemn obligations" of treaties with other countries.

Then, in words that should strike a responsive note in the hearts of all Americans, Senator Goldwater told President Reagan:

"I am making this personal plea to you, Mr. President . . . because as a member of the United States Senate, as an American citizen, who has lived most of his life with these Indians, I'm just plain fed up, sick and tired of the neglect of these people while at the same time you are asking us for millions, hundreds of millions, yes billions of dollars, to give to people scattered around this world to help in establishing human rights.

"Please, Mr. President, let's establish something in our own back yard that we can begin to be proud of before we wander around this earth trying to teach other people how to live and how to act toward each other. Let's act toward each other in this country like we really meant what we talk about."

SISSETON-WAHPETON SIOUX TRIBE
 OF THE
 LAKE TRAVERSE RESERVATION

SISSETON, S.D. 57267



COUNCIL RESOLUTION NO. 82-42

- WHEREAS, The Sisseton-Wahpeton Sioux Tribe of the Lake Traverse Reservation is organized under a Constitution and By-laws adopted by the members of the Tribe on August 1-2, 1966; approved by the Commissioner of Indian Affairs on August 25, 1966; and,
- WHEREAS, Article VII., Section 1, (b), (h), and (i) of the Constitution authorizes the Tribal Council to: (b) represent the Tribe in all negotiations with Federal, State and local governments; (h) to take any action by ordinance, resolution, or otherwise, to carry into effect the foregoing purposes; and, (i) to promote public health, education, charity and other services as may contribute to the social advancement of the members of the Sisseton-Wahpeton Sioux Tribe; and,
- WHEREAS, The Sisseton-Wahpeton Sioux Tribal Council has established the Human Services Board as advisory and policy-recommending in matters pertaining to the health and welfare of Tribal members; and,
- WHEREAS, LACK OF PREVENTION was identified as the third major problem on the Lake Traverse Reservation during the 1980 System-Wide Assessment of Human Services Programs, and the Tribal Specific Health Plan states that the result is reactive, crisis-oriented, and dependency fostering service delivery - responding to the costly, self-destructive behaviors which have already resulted in Court actions, extensive medical care, debilitating accidents, and/or property damage and loss; and,
- WHEREAS, The United States Congress established the Contract health Service Programs as one of three funded health care resources, for the purpose of providing Indian Health Service physicians with the discretionary capacity to refer Indian patients to tertiary and specialized medical care providers outside the Indian Health Service System; but,
- WHEREAS, The amount of money the Government has appropriated for Contract Health Services is INADEQUATE because of the escalating costs of hospitalization and physicians services and because of the increasing demands placed on this resource by medical conditions requiring services which the Indian Health Service does not have the inhouse capacity to provide; and,

WHEREAS, Service Unit staff have estimated that in FY 81, 48% of the total \$588,658.00 budget spent was for alcohol-related emergencies, and that 31% of the budget went for only 31 alcohol cases, while in the meantime the Medical Authorizations for other patients were not made because their conditions were categorized at lower priority levels and there were no funds to refer them out; and,

WHEREAS, Since October, 1981, the Service Unit has been directed to operate the Contract Health Service Program at 80% of their FY 81 base allocation and are prohibited from referring out any patient whose condition is not medically determined to be a Priority #1, defined as an, "A. Immediate medical emergency; life-threatening situation; or, B. Potential life-threatening situation if preventive measures are not taken;" and,

WHEREAS, As a result of this policy and the lack of funds, Indian patients are not benefiting from early medical diagnosis/treatment and preventive health care; and,

WHEREAS, The Human Services Board asserts that it is obvious that treating a condition at the stage when it becomes emergent and hospitalization and/or extensive, costly therapeutic measures are required is LESS COST-EFFECTIVE than early diagnostic and preventive care; and,

WHEREAS, The Human Services Board further asserts that the present system of care truly results in a HARDSHIP to patients and ADVERSELY AFFECTS THEIR HEALTH and the quality and productivity of their lives; and,

WHEREAS, These assertions are consistent with the Tribal Specific Health Plan which ranks "Early Diagnosis and Preventive Contract Health Care" as the first priority need for additional resources, and calculates the percentage of unmet need to be 81.8%, according to the 1979 application of the Resource Allocation Criteria (R.A.C.).

NOW THEREFORE BE IT RESOLVED: That the Tribal Council of the Sisseton-Wahpeton Sioux Tribe supports the recommendation of the Human Services Board and hereby protests the inadequate allocation of Contract Health Service dollars to the Indian Health Service and the resulting policy that these funds be spent to treat Priority 1, medical conditions only.

AND BE IT FURTHER RESOLVED: That the Sisseton-Wahpeton Sioux Tribe hereby requests that additional monies be appropriated for the Contract Health Service Program and that a reasonable portion of these be earmarked for early diagnostic consultation and preventive health care in accordance with the approach outlined in the Tribal Specific Health Plan Update, 1981.

C E R T I F I C A T I O N

We, the undersigned duly elected Chairman and Secretary of the Sisseton-Wahpeton Sioux Tribal Council do hereby certify that the above resolution was duly adopted by the Sisseton-Wahpeton Sioux Tribal Council, which is composed of 18 members, of which 16 members, constituting a quorum were present at a Tribal Council meeting duly noticed, called, convened, and held at Tiwakan Center, Sisseton, South Dakota, on March , 1982, by a vote of 15 for; 0 opposed; 1 not voting; and that said resolution has not been rescinded or amended in any way.

Dated this 2nd day of March, 1982.

Carol Jordan

Carol Jordan, Tribal Secretary
SISSETON-WAHPETON SIOUX TRIBAL COUNCIL

ATTEST:

Rollin V. Ryan

Rollin Ryan, Tribal Chairman
SISSETON-WAHPETON SIOUX TRIBAL COUNCIL

SISSETON-WAHPETON SIOUX TRIBE
 OF THE
 LAKE TRAVERSE RESERVATION
 SIOUX COUNTY S. DAK. 57232



EXECUTIVE RESOLUTION NO. 82 - 31

- WHEREAS, The Sisseton-Wahpeton Sioux Tribe of the Lake Traverse Reservation is organized under a Constitution and By-laws adopted by the members of the Tribe on August 1-2, 1966; approved by the Commissioner of Indian Affairs on August 25, 1966; and,
- WHEREAS, Article VIII., Section 1, (a) and (h) of the Constitution authorizes the Tribal Council to represent the Tribe in all negotiations with the Federal, State, and local governments and to promote public health, education and such other services as may contribute to the social and economic advancement of the members of the Sisseton-Wahpeton Sioux Tribe; and,
- WHEREAS, Article III., Section 2, authorizes the Executive Committee (informal session) with the "power to speak and act for the Tribe when the Tribal Council is not in session"; and,
- WHEREAS, The Sisseton-Wahpeton Sioux Tribal Council has established the Human Services Board as advisory and policy-recommending in matters pertaining to the health and welfare of Tribal members; and,
- WHEREAS, Since the enactment of the Snyder Act in 1921, the United States Congress has appropriated funds to carry out the Government's fiduciary responsibilities to provide health benefits to Native American people; and,
- WHEREAS, Case law, White v. Califano, holds that the Federal Government has a trust responsibility to provide health care for Indian people; and,
- WHEREAS, The Indian Health Service branch of the Public Health Service, Department of Health and Human Services, has its mission stated "to ensure equity, availability and accessibility of a comprehensive high quality health care delivery system providing maximum involvement of American Indians and Alaskan Natives in defining their health needs and setting health priorities for their health program"; and,

WHEREAS, Pursuant to the Indian Health Care Improvement Act (P.L. 94-437), which required the Secretary of Health, Education, and Welfare to report on the status of the Indian health care delivery system, a National Plan for Fiscal Years 1981-84 was prepared, incorporating data from a comprehensive Tribal and urban specific planning process; and,

WHEREAS, The National Plan projected that the total additional resources needed for FY 81-84 would be 12,365 staff and \$2,849,301,000.00; and,

WHEREAS, The Sisseton-Wahpeton Sioux Tribe participated in and, thereby, committed its resources to the development of a Tribal Specific Health Plan in good faith that the Government would consider the plight of Indian people for additional health care funding; but,

WHEREAS, The Reagan Administration, in its efforts to balance the Federal budget, has disregarded this previous work, and the Office of Management and Budget has mandated that monies be reprogrammed from existing line items (such as Maintenance and Repair, Equity Health Care, Contract Health Care, and Facilities) to cover the \$18.2 million Pay Act obligation and a \$9.3 million deficit in the Hospital and Clinics line item of the IHS FY 82 budget; and,

WHEREAS The Indian Health Services requested the authority to ask Congress for a supplemental add-on appropriation to their FY 82 budget, but the Office of Management and Budget has denied IHS their request; and,

WHEREAS, It is expected that the net effect of the proposed budgeting "reprogramming" will mean drastic reduction in services and possible closing of some facilities.

NOW THEREFORE BE IT RESOLVED: That the Sisseton-Wahpeton Sioux Tribal Council supports the recommendation of the Human Services Board and hereby requests that the United States Congress fulfill its fiduciary responsibility and provide a \$27.5 million supplemental appropriation so as to maintain current level operation of the Indian Health Service programs for the benefit of the American Indian people.

C E R T I F I C A T I O N

We, the undersigned, duly elected Chairman and Secretary of the Sisseton-Wahpeton Sioux Executive Council do hereby certify that the above resolution was duly adopted by the Executive Council, which is composed of 3 members, of whom 3 members, constituting a quorum, were present at an Executive meeting duly noticed, called, convened and held at Tiwakan Center, Sisseton, South Dakota, on April 22, 1982, by a vote of 3 for, 0 opposed, 0 not voting, and that said resolution has not been rescinded or amended in any way.

Dated this 22nd day of April, 1982.

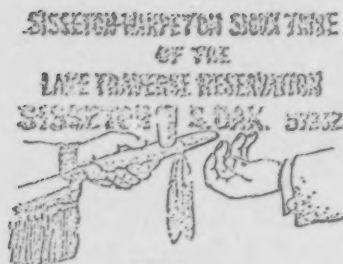
Arnold R. Ryan

Arnold Ryan, Tribal Treasurer
Sisseton-Wahpeton Sioux Tribal Council

ATTEST:

Rollin V. Ryan

Rollin V. Ryan, Tribal Chairman
Sisseton-Wahpeton Sioux Tribal Council



COUNCIL RESOLUTION NO. 82-57

WHEREAS, the Sisseton-Wahpeton Sioux Tribe of the Lake Traverse Reservation is organized under a Constitution and By-laws adopted by the members of the Tribe on August 1-2, 1966; approved by the Commissioner of Indian Affairs on August 25, 1966; and,

WHEREAS, Article VII, Section 1 (a), (g), and (h) of the Constitution authorizes the Tribal Council to, (a) represent the Tribe in all negotiations with Federal, State, and local governments; (g) to take any action by ordinance, resolution or otherwise which are reasonably necessary, through committees, boards, agents, or otherwise, to carry into effect the foregoing purposes; and, (h) to promote public health, education, charity, and other services as may contribute to the social advancement of the members of the Tribe; and,

WHEREAS, the Sisseton-Wahpeton Sioux Tribe has learned of the following:

1. The Aberdeen Area Indian Health Service (IHS) is far from meeting their goal of raising the health status of the American Indian,
2. Along with the current Indian Health Service (IHS) budget cuts, unmet health care needs, and steadily decreasing health care services, the Indian Health Service (IHS) has a current 10 million dollar deficit which is obviously due to mismanagement,
3. Each Indian Health Service (IHS) Service Unit has a revenue resource from Medicare and Medicaid funds which are generated from the individual Indian Health Service (IHS) Service Units,
4. Each Service Unit within the Aberdeen Area has the right to utilize revenue collected to correct any existing deficiencies at their Unit including contract health care needs, or other unmet health care needs of their local service population; and,

WHEREAS, It has been revealed that the Indian Health Service plans on closing the Tribe's Sisseton Service Unit's in-patient care facility, converting the facility to an out-patient only institution, while referring patients needing in-patient care to Fort Yates, North Dakota; and,

WHEREAS, Fort Yates, North Dakota is located over 250 miles northwest of Sisseton, South Dakota, which would jeopardize the health of patients;

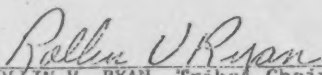
NOW, THEREFORE, BE IT RESOLVED, by the Tribal Council of the Sisseton-Wahpeton Sioux Tribe, that a comprehensive report needs to be given to each tribal group which receives primary health care from Indian Health Service (IHS) at least annually which includes at a minimum the following: A breakdown on the budget by Area on Program Management, Environmental Health, Mental Health, Health Education, Contract Health Services, Dental, Optometry, Public Health Nursing, etc.; population served, facilities and equipment maintenance and repair, analysis and collection of Medicare and Medicaid revenue. That a Congressional Investigation be made on Indian Health Service (IHS) for mismanagement of funds. That any Medicare and Medicaid revenue collected by the Service Units be kept at that Service Unit level to cover the cost of unmet health care needs. That any budget cuts, or reorganizational plans made by the Aberdeen Area Office have prior approval and involvement in developing a plan for the Tribal Chairmen of the Area. That each tribal organization within the Aberdeen Area receive a Comprehensive Annual Report on the Status of the Aberdeen Area Health Care Delivery System; and,

BE IT FURTHER RESOLVED, that the Sisseton-Wahpeton Sioux Tribe herein opposes closing of the Sisseton Service Unit's in-patient care facility.

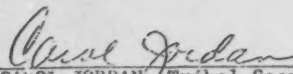
C E R T I F I C A T I O N

We, the undersigned duly elected Chairman and Secretary of the Sisseton-Wahpeton Sioux Tribal Council, do hereby certify that the above resolution was duly adopted by the Sisseton-Wahpeton Sioux Tribal Council, which is composed of 18 members, of whom 14 members, constituting a quorum, were present at a Tribal Council meeting duly noticed, called, convened and held at Tiwakan Center, Sisseton, South Dakota, on May 4, 1982, by a vote of 13 for; 0 opposed; 1 not voting; and that said Resolution has not been rescinded or amended in any way.

Dated this 4th day of May, 1982.


ROLLIN V. RYAN, Tribal Chairman -
Sisseton-Wahpeton Sioux Tribal Council

ATTEST:


CAROL JORDAN, Tribal Secretary
Sisseton-Wahpeton Sioux Tribal Council

SISETON-WAHPETON SIOUX TRIBE
OF THE
LAKE TRAVERSE RESERVATION
SISSETON, S. DAK. 57232



COUNCIL RESOLUTION NO. 82-93

- WHEREAS, The Sisseton-Wahpeton Sioux Tribe of the Lake Traverse Reservation is organized under a Constitution and By-laws adopted by the members of the Tribe on August 1-2, 1966; approved by the Commissioner of Indian Affairs on August 25, 1966; and,
- WHEREAS, Article VII, Section 1, (b), (h), and (i) of the Constitution authorizes the Tribal Council to: (b) represent the Tribe in all negotiations with Federal, State and local governments; (h) to take any action by ordinance, resolution, or otherwise, to carry into effect the foregoing purposes; and, (i) to promote public health, education, charity, and other services as may contribute to the social advancement of the members of the Sisseton-Wahpeton Sioux Tribe; and,
- WHEREAS, The Sisseton-Wahpeton Sioux Tribal Council has established the Human Services Board as advisory and policy-recommending in matters pertaining to the health and welfare of Tribal members; and,
- WHEREAS, Since 1921, when the United States Congress enacted the Snyder Act, funds have been annually appropriated to carry out the Government's fiduciary responsibilities to provide health care benefits to Native American people; and,
- WHEREAS, Through the years the Government has established rules and regulations to govern the administration and delivery of health care services to Indians in Part 36, Title 42 of the Code of Federal Regulations, including Subpart A - "Purpose and Definitions," Subpart B - "What Services are Available and Who is Eligible for Care?", and Subpart C - "Contract Health Services;" and,
- WHEREAS, Recently eligibility for Indian health care benefits was expanded (as per Federal Register, Volume 46, No. 154, dated Tuesday, August 11, 1981, and Transmittal Notice IHS Manual TN - No. 82-1, dated January 27, 1982) to include non-Indian spouses and other non-Indian relatives residing in the households of eligible Indian persons; but,
- WHEREAS, The United States Government has appropriated no additional funds for the Indian Health Service to meet the needs of this increased workload; and,

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WHEREAS, At the same time, the Reagan Administration, in its efforts to balance the Federal Budget and reduce all Government spending, is pressing for funding cuts (rather than increases) in Indian health care programs; and,

WHEREAS, The National Plan prepared pursuant to the Indian Health Care Improvement Act (P.L. 94-437) of November, 1976, which required the Secretary of Health, Education, and Welfare to report on the status of Indian health care delivery systems, projected that the total additional resources needed for FY's 81-84 would be 12,365 staff and \$2,849,301,000.00, thereby confirming that the Indian Health Service is grossly underfunded to fulfill its responsibilities to Indian patients; and,

WHEREAS, It is expected that the net effect of inadequate funding, further budgetary cutbacks, and the increased workload demand of serving non-Indian spouses and other non-Indian relatives residing in the households of eligible Indian persons will have DEVASTATING impact on the health care resources available to Indian people.

NOW THEREFORE BE IT RESOLVED: That the Sisseton-Wahpeton Sioux Tribal Council supports the recommendation of the Human Services Board and hereby petitions the Tribal leaders attending the Great Sioux Nations Annual Meeting on August 4-6, 1982, to urge Congress to change the present, broadened criteria for eligibility for Indian health care benefits to exclude all non-Indian spouses and other non-Indian relatives residing in an eligible Indian person's household and to, instead, require proof of one-quarter degree Indian blood quantum as a condition for eligibility.

C E R T I F I C A T I O N

We, the undersigned duly elected Chairman and Secretary of the Sisseton-Wahpeton Sioux Tribal Council do hereby certify that the above resolution was duly adopted by the Sisseton-Wahpeton Sioux Tribal Council, which is composed of 18 members, of which 15 members, constituting a quorum were present at a Tribal Council meeting duly noticed, called, convened, and held at Tiwakan Center, at Sisseton, South Dakota, on August 2, 1982, by a vote of 14 for; 0 opposed; 1 not voting; and that said resolution has not been rescinded or amended in any way.

Dated this 2nd day of August, 1982.

Carol Jordan
Carol Jordan, Tribal Secretary
SISSETON-WAHPETON SIOUX TRIBAL COUNCIL

ATTEST: *Rollin V. Ryan*
Rollin V. Ryan, Tribal Chairman
SISSETON-WAHPETON SIOUX TRIBAL COUNCIL

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- (E. Eligibility - To be eligible for CHS, an individual must meet the eligibility requirements of 42 CFR 36.2, as well as the additional requirements of 42 CFR 36.23 that an individual must:
- (1) Reside within the United States and on a reservation located within a CHSDA; or
 - (2) Reside within the United States near a reservation and
 - (a) within a CHSDA, and
 - (b) be a member of the tribe or tribes located on that reservation or maintain close economic and social ties with such tribe or tribes, or
 - (3) Be married to an eligible Indian and reside in the household of that eligible Indian, or
 - (4) Be a non-Indian member of an eligible Indian's immediate family and reside in the household of that eligible Indian, or
 - (5) Be the surviving non-Indian spouse of an eligible Indian and continuing to live in the community served by the local facilities and program and has not remarried a non-eligible individual, or
 - (6) Be a student or transient. CHS will be made available to students and transients who would be eligible for CHS at the place of their permanent residence within a CHSDA, but who are temporarily absent from their residence, as follows:
 - (a) Students—during their full-time attendance at programs of vocational, technical, or academic education, including normal school breaks, such as vacations, semester or other scheduled breaks occurring during their attendance, and for a period not to exceed 180 days after the completion of the course of study.
 - (b) Transients (persons who are in travel or are temporarily employed, such as seasonal or migratory workers), during their absence.
 - (c) Other persons outside the CHSDA. Persons who leave the CHSDA in which they are eligible for CHS and are neither students nor transients will be eligible for CHS for a period not to exceed 180 days from such departure.

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(7) Foster Children - Indian children who are placed in foster care outside a CHSBA by order of a court of competent jurisdiction and who were eligible for CHS at the time of the court order shall continue to be eligible for CHS while in foster care.

(8) Other Eligibility Considerations:

- (a) The regulations do not require that a person of Indian descent actually be a member of a federally recognized tribe as long as he/she belongs to the Indian community served by the local IHS facility and program.
- (b) An Indian is not required to be a citizen of the United States to be eligible for CHS. The Indian, e.g., Canadian or Mexican, must reside in the United States; be a member of a tribe, or a descendant of a member of a tribe, whose traditional land is divided by the Canadian border (i.e., St. Regis Mohawk, Blackfeet) or Mexican border (i.e., Papago).
- (c) Terminated Indians are excluded from eligibility by termination statutes unless they meet other criteria making them eligible (i.e., spouse).

In accordance with Section 709 of P.L. 96-537, as of October 1, 1981, all terminated Indians of California are eligible for IHS services if they otherwise qualify under IHS regulations.

Section 709 made distributees, their children born after termination, and dependents of such children eligible for IHS services. Their eligibility lasts until September 30, 1984, unless there is intervening court or legislative action to the contrary.

Dependents of distributees who were included in California rancheria distribution plans and/or in termination notices were restored to eligibility by court action as a result of the Duncan and Knight cases. Descendants of these dependents are also eligible as an outgrowth of the court action. The eligibility of these dependents will continue beyond September 30, 1984, unless there is legislative or court action to the contrary.

Anyone receiving services based only on Section 709 eligibility (Distributees, their post termination children, and descendants of such children) should be notified at the time service is provided that their eligibility under Section 709 lasts only to September 30, 1984.

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- (d) Non-Indian divorcees are excluded from eligibility.
- (e) Indians, adopted by non-Indian parents, who meet all other requirements are eligible for CHS.
- (f) The pregnant, unmarried non-Indian female who resides within a CHSDA is eligible for CHS if an eligible Indian male states in writing he is the father of the unborn child. This will ensure health services to the unborn Indian child.

F. Close Social and Economic Ties - Individuals claiming eligibility for CHS under this category have the responsibility to furnish the SUD sufficient documentation to substantiate their claim. The individual must be certified as having close social and economic ties by a tribe whose reservation is located within a CHSDA in which the applicant lives. This certification can be by whatever normal and proper procedure is followed by the individual tribe; (e.g., Tribal Resolution or other process authorized by Tribal Resolution). Basis for determining eligibility may be: (1) employed by a tribe whose reservation is located within a CHSDA in which the applicant lives, 2) an Indian or non-Indian dependent of the eligible Indian who lives in his/her household, or 3) other determination by the tribe.

G. Priorities for CHS

- (1) Regulations permit the establishment of priorities based on relative medical need when funds are insufficient to provide the volume of CHS indicated as needed by the population residing in a CHSDA.
- (a) To the extent possible, Area-wide priorities should be established to ensure an equivalent level of services to all service units; taking into consideration the availability and accessibility of IHS facilities, the population being served, the relative cost of services, and the availability of alternate resources.
- (b) Priorities established to limit services, whether on an Area-wide or SU basis, shall be made known to the Indian population being served through publication in local community and/or tribal newspapers and posting of notices on bulletin boards in patient areas of IHS facilities.

- R. Alternate Resources - As used in this manual, alternate resources are those resources, including IHS facilities, that are available and accessible to an individual. Alternate resources would include but not be limited to, Medicare, Medicaid, vocational rehabilitation, Veterans Administration, crippled children, private insurance, and State programs.
- (1) The use of alternate resources, as defined above, is mandatory.
 - (a) An individual is required to apply for an alternate resource if there is reasonable indication that the individual may be eligible for the alternate resource.
 - (b) Refusal to apply for alternate resources when there is a reasonable possibility that one exists; or refusal to utilize an alternate resource; requires the denial of eligibility for CHS.
 - (c) An individual is not required to expend personal resources for health services to meet alternate resource eligibility or to sell valuables or property to become eligible for alternate resources.
 - (2) Bureau of Indian Affairs (BIA) Employment Assistance Medical program is an alternate resource that is available for BIA Employment Assistance enrollees.
 - (3) Students whose grant includes funds for health services will be expected to use the grant funds to purchase available student health insurance.

2-3.8 AUTHORIZATION FOR CHS

- A. No payment will be made for medical care and services obtained from non-service providers or in non-service facilities unless the applicable requirements of paragraphs (B) and (C) below have been met and a purchase order for the care and services has been issued by the appropriate IHS ordering official to the medical care provider.
- B. In non-emergency cases, a sick or disabled Indian, or an individual or agency acting on behalf of the Indian, or the medical care provider shall, prior to the provision of medical care and services, notify the appropriate IHS ordering official of the need for services and supply information that the ordering official deems necessary to determine the relative medical need for the services and the individual's eligibility.

SISSETON-WAHPETON SIOUX TRIBE
OF THE
LAKE TRAVERSE RESERVATION
SISSETON, S.D. 5702



COUNCIL RESOLUTION NO. 82-94

- WHEREAS, The Sisseton-Wahpeton Sioux Tribe of the Lake Traverse Reservation is organized under a Constitution and By-laws adopted by the members of the Tribe on August 1-2, 1966; approved by the Commissioner of Indian Affairs on August 25, 1966; and,
- WHEREAS, Article VII, Section 1, of the Constitution authorized the Tribal Council to: (b) represent the Tribe in all negotiations with Federal, State, and local governments; (h) to take any action by ordinance, resolution, or otherwise, to carry into effect the foregoing purposes; and, (i) to promote public health, education, charity, and other services as may contribute to the social advancement of the members of the Sisseton-Wahpeton Sioux Tribe; and,
- WHEREAS, The Sisseton-Wahpeton Sioux Tribal Council has established the Human Services Board as advisory and policy-recommending in matters pertaining to the health and welfare of Tribal members; and,
- WHEREAS, In 1921, the United States Congress enacted the Snyder Act and has since that time annually appropriated funds to carry out the Government's fiduciary responsibilities to provide health care/benefits to Native American people; and,
- WHEREAS, The mission statement of the Indian Health Service branch of the Public Health Service, Department of Health and Human Services is "To ensure equity, availability, and accessibility of a comprehensive high quality health care delivery system, providing maximum involvement of American Indians and Alaskan Natives in defining their health needs and setting priorities for their health programs"; and,
- WHEREAS, The National Plan prepared pursuant to the Indian Health Care Improvement Act (P.L. 94-437) of November, 1976, which required the Secretary of Health, Education, and Welfare to report on the status of Indian health care delivery systems, projected that the total additional resources needed for FY's 81-84 would be 12,365 staff and \$2,849,301,000.00; and,
- WHEREAS, The National Plan, therefore, confirmed the fact that the Indian Health Service is grossly underfunded to fulfill its responsibilities to Indian patients; and,

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- WHEREAS, The Indian Health Care Improvement Act authorized the Indian Health Service to collect third party payments for Indian patients who are Medicare/Medicaid eligible as a supplementary funding mechanism but does not, however, stipulate that the monies collected should remain in the same Area and at the same Service Unit which collected them; and,
- WHEREAS, The Medicare/Medicaid monies collected at the Sisseton-Wahpeton Service Unit and by the Aberdeen Area, overall, have been submitted to IHS Headquarters and, from there, were largely redistributed to other Areas which did not collect as actively; and,
- WHEREAS, At the same time, the Reagan Administration, in its efforts to balance the Federal Budget and to reduce all Government spending, is pressing for funding cuts in Indian health care programs; and,
- WHEREAS, In response to the inadequate allocation and distribution of resources to the Aberdeen Area, the Indian Health Service Area Director had proposed a Reorganization Plan, designed to provide an optimal level of health care with the dollars that are available by eliminating the inpatient care facilities on some Reservations (Sisseton and Wagner) and arranging for these services to be provided at others (Ft. Yates, Pine Ridge); and,
- WHEREAS, The Sisseton-Wahpeton Sioux Tribal Council in previously on record, per Resolution Nos. 82-31 and 82-57, to oppose the Reorganization Plan and/or budgetary "reprogramming" because it will mean drastic reduction in the availability and accessibility of services to Tribal members on the Lake Traverse Reservation; and,
- WHEREAS, The Area and National Directors of the Indian Health Service encouraged Tribal leaders attending the Aberdeen Area Tribal Chairmen's Association Meeting in Bismarck June 7-8, 1982, to come up with alternative plans that would be more feasible to Indian people; and,
- WHEREAS, The Human Services Board recommends two, related alternative plans, as follows:
1. To petition Congress to authorize the Indian Health Service to collect third party payments from private health insurance carriers and, further, to allow the revenues raised thereby to be utilized at the Service Unit where it was collected.
 2. To petition Congress to change the present, broadened eligibility criteria which allows non-Indian spouses and other non-Indian relatives residing in the households of eligible Indian persons to participate in Indian health care programs and to, instead, authorize the Indian Health Service to collect monies for services rendered to non-Indian spouses and other non-Indian relatives residing in the households of eligible Indian persons and reprogram these within the Service Unit where they are collected.

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08-07-82
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NOW THEREFORE BE IT RESOLVED: That the Sisseton-Wahpeton Sioux Tribal Council supports the recommendation of the Human Services Board and hereby requests the Tribal leaders attending the Great Sioux Nations Annual Meeting on August 4-6, 1982, to petition Congress to authorize the Indian Health Service to supplement their budget by collecting third party payments from private health insurance carriers, as well as by charging non-Indian spouses and other non-Indian relatives residing in the households of eligible Indian persons, and, further, to allow the Indian Health Service to utilize the revenues raised thereby to subsidize the operations of the Service Units which collect these.

C E R T I F I C A T I O N

We, the undersigned, duly elected Chairman and Secretary of the Sisseton-Wahpeton Sioux Tribal Council do hereby certify that the above resolution was duly adopted by the Sisseton-Wahpeton Sioux Tribal Council, which is composed of 18 members, of which 15 members, constituting a quorum were present at a Tribal Council meeting duly noticed, called, convened, and held at TiWakan Center, at Sisseton, South Dakota, on August 2, 1982, by a vote of 14 for; 0 opposed; 1 not voting; and that said resolution has not been rescinded or amended in any way.

Dated this 2nd day of August, 1982.

Carol Jordan
Carol Jordan, Tribal Secretary
SISSETON-WAHPETON SIOUX TRIBAL COUNCIL

ATTEST: Rodlin V. Ryan
Rodlin V. Ryan, Tribal Chairman
SISSETON-WAHPETON SIOUX TRIBAL COUNCIL

Senator ANDREWS. Our last two witnesses are Eleanore Robertson, registered nurse, director of the Aberdeen Area Indian Health Service; and John Buckanaga, the director of the Bemidji Indian Health Service Program Office. They are going to be accompanied by Mr. Howard Roach who is the associate director of administration for the Indian Health Service.

Good to have you here. You have listened to a number of statements and I am sure that it is going to be interesting to see what kind of response you have to some of them. Eleanore, I understand you have a statement.

Mr. ROACH. Mr. Chairman, may I make one comment to start off? Senator ANDREWS. Surely.

STATEMENT OF HOWARD ROACH, ASSOCIATE DIRECTOR OF ADMINISTRATION, INDIAN HEALTH SERVICE

Mr. ROACH. As you mentioned, my name is Howard Roach and I am the associate director of administration for Indian health service. On the far left of the table is Mr. Allen Alec who is the executive officer for the Aberdeen area office. Next to him, of course, is Ms. Eleanore Robertson and Mr. Buckanaga to my immediate left.

In the interest of time I have provided a brief opening statement for the record and will just state that my role here primarily is to be of assistance to Ms. Robertson and Mr. Buckanaga if it is needed. I realize that you had the opportunity to have a hearing on this subject earlier this year.

Senator ANDREWS. We did and you were there.

Mr. ROACH. You know then that the primary purpose of this hearing is just to get a prospectus from the field and I recognize and agree with that and I am just going to be here in assistance if needed.

Senator ANDREWS. We understand that.

You have appeared before the committee on a number of occasions before and what, a month or two before?

Mr. ROACH. Yes.

Senator ANDREWS. But this was our opportunity to come out in the field and find out how it is out here because very often you see a little different picture presented when you go out in the field than you get when you are in the relatively sterile confines of Washington.

I think it is a tribute to you and some of your coworkers, the amount of support that you were given in a rather unique way, I might say, by those who testified here, that if they would turn you loose and let you do what you know how to do, things might be a whole of a lot better than they are.

[The prepared statement follows:]

PREPARED STATEMENT OF HOWARD ROACH, ASSOCIATE DIRECTOR FOR ADMINISTRATION, INDIAN HEALTH SERVICE, PUBLIC HEALTH SERVICE, HHS

Mr. Chairman and members of the committee, I am Mr. Howard Roach, Associate Director for Administration of the Indian Health Service (IHS). With me are Ms. Eleanore Robertson of the Aberdeen Area Office and Mr. John Buckanaga of the Bemidji Program Office. I am pleased to be here today in North Dakota. Ms. Robertson and Mr. Buckanaga will be glad to discuss with you and your Committee any questions about the operation of the health care programs by IHS in the local area and I will be glad to discuss with you any overall policy questions.

As you know, the IHS represents the primary Federal health commitment to approximately 900,000 eligible American Indians and Alaska Natives living on or near Federal Indian reservations and in traditional Indian Country. The IHS carries out this mission through a comprehensive health delivery system providing high quality preventive, curative, rehabilitative, and environmental health services. It does this through programs managed and operated by both the IHS and various tribes utilizing both direct and contract health services. In addition, limited health services are provided in 37 urban locations having an Indian population of about 300,000—half of whom are included in the 900,000 figure. Two of these projects are in Nebraska and South Dakota, and four are in Michigan, Minnesota and Wisconsin.

The total IHS service population for the Aberdeen Area Office is approximately 68,088 and for the Bemidji Program Office is approximately 45,682.

To date the fiscal year 1983 appropriation to the IHS for health services totals \$858,183,000.00. The IHS Area's apportion of the fiscal year 1983 appropriation includes \$56,795,300.00 for Aberdeen and \$26,631,000.00 for Bemidji.

The IHS is constantly endeavoring to provide quality health care to Indian people while recognizing that the medical needs of Indian people demand a special measure of priority and attention from the Federal Government.

In 1976, in the Indian Health Care Improvement Act, the Congress defined the scope of the IHS program and established a national goal of providing the highest possible health status to Indian people while encouraging maximum Indian participation in health programs.

In your letter of invitation you stated that you wished to discuss the need to reauthorize the Indian Health Care Improvement Act, Public Law 94-437. As you know, section 701 requires the Secretary to submit to Congress a final report on Public Law 94-437 including an assessment and recommendations. That process has only recently been initiated so I cannot at this time report on any Departmental decisions.

Mr. Chairman, that concludes my opening remarks. At this time we will be happy to answer any questions you may have.

Senator ANDREWS. Ms. Robertson, please proceed.

STATEMENT OF ELEANORE ROBERTSON, R.N., DIRECTOR, ABERDEEN AREA INDIAN HEALTH SERVICE

Ms. ROBERTSON. All right. I will be happy to begin.

First of all, I want to thank you for the invitation permitting me to come before this committee hearing and to comment on the health care system. I think I would like to just comment on a few things that I see as area director and that is No. 1, I think there is no doubt that the health care has improved within the Indian community since 1955. We have seen a decline in the birth rate and the death rate. We have seen life expectancy increased. Tuberculosis has been all but eradicated but it is a sleeper and we cannot ignore that. We need to watch that one very carefully.

The Indian people are using the clinics more. Hospitalizations are less prolonged. They seem to be less ill, but there are some other problems that I want to just address briefly.

All of this is in the record and I am sure you have been told these statistics many, many times before, so I am not going to belabor those and just repeat some of those.

There are some things I think this committee needs to hear about and that is that there are alarmingly high death rates among young adults, the 18-to-24 age group. They die much faster and sooner than the rest of their counterparts in the non-Indian community. In fact the death rate is three times higher and the leading causes of death are traumatic accidents, homicide, suicide, and alcoholism.

Senator ANDREWS. What are the most prevalent health problems among Indians?

Ms. ROBERTSON. I think probably alcoholism is the No. 1 health problem, diabetes and all of the other—

Senator ANDREWS. As an offshoot from alcoholism?

Ms. ROBERTSON. No. I do not believe so. Indian people react very peculiarly to diabetes. For example, they can tolerate a very high blood sugar of 700 milligrams per 100 cubic centimeters of blood, but the average for a non-Indian is 120 milligrams, so they react quite differently physiologically to diabetes.

However, you see a great number of amputations in a relatively young age group and with no rehabilitation and no followup care for that person, that person's chances, their quality of life, of course, is severely diminished on the reservation and I can quote you all kinds of statistics if you would like.

I think there is an increase of evidence of child abuse, even sexual child abuse of young children of 3 and 4 years of age. We are establishing some child abuse teams with our mental health and social service people, but of course those people are not very great in number. The health care system budget cuts mean that the social services are first to go, yet they should be the last to go, because of the lack of employment and the important economic situation on the reservation.

Mental health is severely impaired. People are anxious about their futures. They have emotional problems. Families begin to have problems. I do not have any hard data to give you on this, but I know it is happening and I do not know what it will look like 10 years from now.

While we have had a dramatic decrease in the incidents of tuberculosis—in fact we had a 53-percent increase in the Aberdeen area. That was an increase of 22 cases over those we saw in 1981. However, it is making a comeback. I want to make this statement for the record: In the first 5 months of 1983 we have identified 17 cases of class 3 active TB and during the same time last year we had only 4 cases. We had 1 case each from Nebraska and North Dakota and 15 from South Dakota. The youngest patient was 3 years old and the oldest was 90 years old, so it is no respecter of age or whether you are a senior citizen or not.

Venereal disease is still a problem in this area and while the other parts of the country are seeing a decrease in gonorrhea we have seen a 32-percent increase in 1982. Infectious syphilis, which was a rarity in this area, is now being reported more frequently and we have had a recent outbreak in South Dakota which affected nine people.

Senator ANDREWS. In the general American health care arena, they say venereal diseases have been essentially brought under control because of the access to treatment and the new wonder drugs and all that. You show a curve that is going in totally the wrong direction. Is that because we do not have enough physicians? The Indian people on the reservations do not have the confidence in the health care delivery system so that they feel free to come in and consult with the doctors or the paramedicals who are there.

Ms. ROBERTSON. I would agree and disagree with your statement. Is it permissible to disagree with a Senator?

Senator ANDREWS. Oh, surely. We have come to be professionals in having been disagreed with over a period of time.

Ms. ROBERTSON. Yes. I agree there are not enough physicians. I agree to a degree, but not totally, that there is a distrust in the health care system.

But I think we are seeing—I cannot prove this, but I think there is a population of people who are coming back to the reservation health care systems who have lived in other parts of the States or who have jobs in the urban areas but cannot afford health care, or have lost their jobs, and are coming back to us. We will probably see those show up in our statistics in a year from now.

One of the things that I think has been really disastrous, and may be more of a disaster, is a decreased number of key outreach workers like the community health representatives. We have a population of 68,000 people. Unless you increase funds somewhere—I know the administration does not like to hear that—then I believe that you are going to see instances of diseases that should not be occurring at all.

I think it is a CHR who can identify with a patient in the community. They feel comfortable in relating to her. They can talk to that person, Lakota or Dakota or Chippewa, whatever, and they are better able to communicate with that person.

I think that is one of the tragedies that I see in this kind of budget cutting climate. You are just seeing evidence of that in incidences of diseases that should not be occurring.

The only other two comments I would like to make is that we did have an outbreak, or apparent increase, of sudden infant death syndrome cases in 1982 at Pine Ridge and that prompted an epidemiologic investigation. We utilized the Center for Disease Control people in Atlanta as well our own representative. All the results of that study are not in. However, I think the study does indicate that these infants were born and the mothers had severe handicaps. They were young mothers who already were alcoholics. They were anemic. They had poor nutrition. They had little or no prenatal care and for the most part no postnatal care and it seems to me, here again, that that is all related to an outreach program and without one, that is going to have what I consider disastrous results.

The only other comment I would like to make is in terms of alcoholism. In October of last year, we made a decision to start looking at alcoholism in terms of prevention because I think that is the name of the game. We are spending more and more of our contract health money on alcoholic complications, either cirrhosis of the liver or operations that require intensive hospitalization, and we have begun what I consider to be one of the most innovative programs in the Indian Health Service, which is to introduce the Babes program, a basic alcoholic education program, at Head Start. We initiated the program at St. Francis in South Dakota on the Rosebud Reservation. To date we have had sessions and classes. This program is very innovative and it uses puppets so that children can learn how to make and keep decisions. Maybe they will make a decision not to drink.

We will not see an impact, I suppose, from that program for at least 10 years, but for a \$200 kit and just the interest of the tribe and the health education workers, we have already conducted what I call

shows for about 400 children between kindergarten and the eighth grade so I am very pleased with that program. I will be happy to answer any questions.

Senator ANDREWS. I appreciate your appearance and the testimony you submitted.

In your opinion are there adequate facilities and equipment in your area to support the medical personnel needs and the medical equipment needs?

Ms. ROBERTSON. No, there are not.

Senator ANDREWS. Do you have a sufficient number of health personnel to address the need for medical treatment in your area?

Ms. ROBERTSON. In my opinion, we do not.

Senator ANDREWS. Would you estimate, in percentage, how much you are short?

Ms. ROBERTSON. I would guess our total staffing for this area is—we are about 48 percent of what we should be. I would like to have 70 percent.

Senator ANDREWS. But the point is that you only have half of the personnel that you need to do the job that you perceive as a professional needs to be done out there.

Ms. ROBERTSON. That is correct.

Senator ANDREWS. I understand that there has been a chronic shortage of doctors in some of the areas within your service area. Is anything being done to remedy this shortage of doctors?

Ms. ROBERTSON. Yes. You are right. There has been a chronic shortage.

Our recruitment—while you are seeing a glut of physicians in the cities, in the large medical centers—

Senator ANDREWS. Those statistics, as I said earlier, that OMB throws out is that we do not need anymore.

Ms. ROBERTSON. Right. But those people do not come to isolated areas. There is a report called the Merriam Report that was written in 1924. It cites the same things we are citing right now so not much has changed in 50 years.

However, I do feel that with the INMED program, we are beginning to get those students, medical students, doing clerkships with us. It is really super. It does two things for us. It really perks up the staff to see and have them being educated and to have a medical education program within the service unit. But not only that, I think other people and young people on the reservation will view these folks and see them as role models which I think is very important.

Two things I set out to do is to enter into discussions with the departments of medicine in North Dakota and South Dakota to encourage the utilization of residents in our facilities to help staff with quality physicians. That is beginning to take shape. Slow going, but it is beginning to take shape. So I am very pleased with that.

Senator ANDREWS. Given the shortage of personnel, you have been most candid about that, and I appreciate your putting a finite number on the record.

The other thing that bothered me deeply in the previous testimony is one of these things that comes out and hits you in the eye. You heard a number of tribal witnesses testify concerning the practice that

requires an emergency patient to go to IHS before going to a hospital. That does not make any sense at all.

Now maybe there is something I am missing in it. Why can't you in effect say: "Look! Let us let commonsense and good judgment reign." This is not a matter of shortage of medical personnel in the area. When one of the people in a tribe has a medical emergency, why in God's name can't you allow them to go directly to the nearest medical facility, irrespective of whether IHS happens to be there or does not happen to be there?

There is going to be a competent physician who either puts them in the hospital because they have got an emergency appendectomy or heart attack or something else. Sitting here listening to stories about people who have died because they did not get an emergency situation treated in time, because they have a Mickey Mouse maze of finding your IHS person, go find somebody else, travel another hundred miles, I have to say that that does not make any sense at all among sensible, civilized, caring people. Does it?

Ms. ROBERTSON. Well, of course not.

Within contract health services, for this year, we have been under what we call category 1 emergencies only. We do pay for emergencies. It is true. We have rationed care. That has been going on about 2 or 3 years. That is nothing new.

We have, and do, pay for any emergency that goes to any hospital within this area. If there are incidents where those cases have not been taken care of, patients have died, we have received appeals and I would be happy to look at those cases because they do come to me when they do have difficulties.

Senator ANDREWS. What about the complaint of the Minot hospital that says that they have not been paid? That any time an Indian patient runs up a bill of more than \$8,000 to \$10,000 Indian Health Service says tough?

Ms. ROBERTSON. It is a policy of procurement that once a bill reaches \$10,000 they notify us. We in turn then have to get permission to pay beyond that amount, which we do.

Senator ANDREWS. You do.

Ms. ROBERTSON. Sure. I paid out \$13,000,000 in contract health services this last year.

Senator ANDREWS. I assume you did. The thing that bothers me is having these hospitals on the perimeters of the Indian reservations, having their money held back and their payments jeopardized and all the rest. Certainly they are going to treat the seriously ill Indian patient who shows up, but they may well be less than cheerful in that treatment and that is not a fair break for the tribal member who has to go to that hospital.

Ms. ROBERTSON. I agree.

I would like to point out that we did identify about a thousand people who needed elective surgical procedures that did not qualify for emergency care. That was when we entered into a contract with the University of North Dakota Department of Medicine, to do the surgery at Belcourt, Sacred Heart, the University of Minnesota. We are taking care of those patients. We had a list of over a thousand. We reidentified and came up with 685. We are continuing to take care of 400 or 500 of those people.

Senator ANDREWS. But the real problem is adequate personnel to identify what the needs are because if you identify them earlier you can save a lot of money down the line.

I want to thank you for your candor because of course your answers contradict the Indian Health Service's testimony in the District of Columbia during our budget oversight hearing. I would suspect that you probably know a little bit more about what goes on out in the field than some of the Indian Health Service biggies.

Ms. ROBERTSON. I know what goes on in this area. I cannot speak for the entire area.

Senator ANDREWS. It is one of the refreshing times when we hear straight and honest answers from an eyewitness. I realize we have our representative from Washington here, too. I would just say that if you get any flack rolling downhill from those in power, let us know.

Ms. ROBERTSON. I have been able to deal with that fairly successfully from all sides.

Senator ANDREWS. Oh, I think you can and we are pretty good in helping out, too.

Ms. ROBERTSON. Thank you.

[A portion of the material submitted by Ms. Robertson is retained in committee files. That portion selected for publication follows. Testimony resumes on p. 288.]

REAUTHORIZATION OF PL 94-437

The Aberdeen Area supports fully the reauthorization of all Titles of PL 94-437. This includes full funding of those titles.

The PL 94-437 Title I Scholarship Program has benefited the Aberdeen Area substantially:

- * 28 students have been approved for continuation grants.
 - 18 Nursing
 - 7 Medicine
 - 1 Radiology Technology
 - 1 Speech Pathology
 - 1 Alcohol and Drug Abuse Counseling
- * There are 9 PL 94-437 graduates in the Area.
 - 7 Nurses (R.N.)
 - 1 Pharmacist
 - 1 X-Ray Technology
- * 5 Externs are working in the Aberdeen Area
 - 2 Nursing
 - 2 Medical Students
 - 1 Hospital Administrator

Much still remains to be achieved, however, in this Area as 81 new applications have been submitted for consideration for funding.

In reference to Title II of the original Act which was never adequately funded, the Aberdeen Area still has substantial unmet needs in:

- Maintenance and Repair backlog
- Field Health
- Dental
- Mental Health
- Treatment and Control of Alcoholism.

It is recommended that consideration for full funding of this section be given in the reauthorization of PL 94-437 to alleviate the unmet health needs of Indian people.

As it is, these unmet needs require larger budget outlays in time simply because the cost of doing nothing is not zero. For example, treatment of diabetes now with proper case finding, insulin or nutritional treatment is much less costly than restorative or repairative services at a later date.

The renovation and construction cited in Title III still looms large over the health care system in the Aberdeen Area. New facilities are absolutely necessary at:

	<u># of Beds</u>	<u>New Positions Required</u>	<u>New Staff Quarters Necessary</u>
Rosebud	35	146	76
Pine Ridge	47	195	147
Kyle		46	25
Fort Thompson		46	28
Wagner		31	20

The figures above include both health facilities and staff housing.

Testimony before Congress this year on Rosebud was incorrect in that it indicated controversy between Tribal governments about surgery services. This issue was settled in the Program Information Documents submitted where it is clearly indicated that Pine Ridge warrants surgery and the Rosebud figures fall below the recommended guidelines. The aforementioned figures, however, do not consider isolation factors that would only serve to strengthen the case for surgery.

Title IV must be reauthorized for the Indian Health Service to maintain any semblance of viability. Medicare and Medicaid collections are an integral part of the IHS service delivery and the Indian Health Service cannot survive without them. Further, those resources cannot continue to be offset by \$5-15 million or more, causing the backsliding of accomplishments achieved to date in the areas of accreditation and certification.

The remaining titles should also be extended and appropriations made to support those extensions.

FUNCTIONS AND VALUE OF THE CHR PROGRAM

The CHR Program in the Aberdeen Area has benefited the Indian population immensely since its inception.

Correlations with the decline in inpatient days, the increase in outpatient visits, the increase in live births, the decrease in infant mortality rates, and the decrease in tuberculosis morbidity and the existence of the CHR Program are well documented.

Much, however, still remains to be done in the areas of alcohol abuse, drug abuse, mental health, and venereal disease, just to name a few. The CHR Program is one of the main links in the chain of events that leads to good preventive programs and the conservation of resources spent on acute care.

The CHR's are a positive link in the Indian Health Care system. They are usually members of the Tribes, whereas the Public Health Nurses and doctors often are not. Shared Tribal memberships and shared languages can establish an immediate rapport for the patient who might be anxious about his health or the need for medical care. This rapport can facilitate earlier medical treatment and provide a setting for individual or family health education.

The CHR's are an answer to the critical transportation problem on the Indian Reservations. The lack of dependable transportation is compounded by the great distances between homes and health care facilities on the Aberdeen Area's Reservations. The Community Health Representatives are, for many Indian people - particularly the elderly and women with small children, the only access to medical care.

The CHR Program is a cost-benefit program. Through the CHR's regular and frequent visits to elderly and homebound individuals, unnecessary inpatient medical costs can be avoided. The CHR's can provide homemaker services and certain medical treatment for the elderly who are unable to fully care for themselves in their own homes.

The CHR Program is vital to Indian people and continued full support of the Program is urged.

Attached are recommendations from the National CHR Program. The Aberdeen Area supports those recommendations and encourages their implementation.

FUTURE DIRECTION OF THE CHR PROGRAM

The National CHR Task Force Recommends:

1. That the CHR Program be continued.
2. That the CHR Program retain its unique qualities of providing services in areas of need, where no other program or resource is available, and that the program not be used to supplement IHS staffing.
3. That the IHS, cognizant of organizational constraints, utilize the perspective of Tribal people in enhancing program growth and development.
4. That the reporting system reflect credit for all services provided by CHR's, i.e., work performance as a dental assistant or as a sanitarian.
5. That the Task Force work in developing a CHR Policy Manual be continued with Area/Program and Tribal contractor participation.
6. That funds should be identified and committed at the national level for the effective directorship of the CHR Program which will provide for:
 - A. An IHS Headquarters Program Director position of equal status to other Headquarters Program Director positions.
 - B. A national training initiative that provides for Area-based training activities.
 - C. A national mandatory reporting activity.

Further, such funds should evolve from the current "set aside" for administration of this program in an amount not to exceed \$400,000. Once the budget has been determined for FY 1983 this CHR administrative budget breakdown should be distributed to CHR contractors.

Recommendations Regarding Methods for Meeting CHR Training Needs

It is recommended:

1. That hospital corpsmen training be investigated (regarding Great Lakes area) and that IHS Headquarters followup on whether or not the training arrangement previously proposed is currently available for CHR contractor to take advantage of the training courses.

2. That a strong emphasis on training for CHR staff be continued as part of the total CHR program. This training should respond to training needs identified at the local level. Such training needs should be identified in CHR annual contract proposals with a "dollarized" plan that relates to the capabilities necessary to carry out the scope of work. Training requirements and funds should then be negotiated into the contracts. The National CHR training initiative should assist Areas in meeting those needs. Training should be recognized as an integral part of the program and certification/college credits should be given by the agency/institution providing training.
3. That every effort should be made by IHS to secure training funds from sources other than the CHR budget both within and outside of the IHS.
4. That a study with recommendations be conducted of past and currently available CHR training activities to determine their adequacy in meeting training needs.
5. That training and certification should be carried out in accordance with recognized standards of health care.

Development of Recommendations for Methods of Allocating and/or Reallocating Resources to Accommodate Future Budget Increases or Decreases

It is recommended:

1. That the Community Health Representative Program cannot endure further budgetary cutbacks.
2. That resource allocation should avoid competition as this serves to fragment the Indian communities.
3. That IHS should discontinue tapping CHR funding before allocation to American Indian and Alaska Native organizations, with the exception of the funds identified in recommendation No. (6) under Future Direction of the CHR Program.
4. That the Indian Health Service develop a methodology for the allocation of community health program resources that will utilize three program modules: (1) scope; (2) effectiveness; (3) needs. This methodology should be developed with the active participation of an advisory group consisting of Indian and Alaska Native Community Health leaders.

Program scope criteria should be consistent with those health care delivery settings, functions and areas which have been delineated for the CHR program by this Task Force.

Program effectiveness criteria should include factors which measure medical efficacy and cost effectiveness.

Program needs criteria should be derived from an array of RRM modules which represent community health care needs which are fulfilled by CHR program resources.

The development of this methodology should be done in a manner consistent with the staff paper entitled "Consideration Regarding Future Allocation of CHR Resources".

Furthermore, this methodology should be developed within FY 1983.

5. Recognizing the evolution of the CHR Program from a community outreach liaison health care program to one that principally provides direct health care services, it is recommended further:

That the CHR line item within the IHS budget be shifted from the IHS budget "Preventive Health" category to the "Clinical Services" category and that the CHR budget line item status be maintained.

Development of Recommendations for Data Collection for CHR Program Review and Congressional Request and Inquiries

The CHR Program has been criticized as not being accountable and not complying with reporting requirements. The CHR Task Force has addressed these issues and recommends that reporting requirements be brought into compliance, and that further efforts be made to improve the reporting system to bring about program accountability.

It is recommended:

1. That there be a uniform mandatory reporting system for all programs, and that a clause in each contract be included mandating its use. That the data collection system be designed in such a way that information stored and used will be reflective of program accountability.

It is further recommended that a group (consisting of (1) Tom Bonifield, (2) Tanya Parker, (3) Ada White, President of the National CHR Association, and (4) a Tribal representative) be convened by January 15, 1983, to develop and/or adapt a data system that will provide information for the justification and allocation of CHR program resources at the national level. The system should receive appropriate review and comment by CHR's before implementation.

2. It is recommended that the IHS CHR Manual contain specific reporting requirements.
3. It is recommended that CHR reporting requirements must be specified in each contract and that the contractors be held in compliance with these requirements.
4. It is recommended that the National CHR Coordinator or Director at IHS Headquarters be assigned responsibilities for data collection.

5. It is recommended that data collection from other program activities which has already been collected by IHS be used by inference when appropriate to credit the CHR's.
6. The accountability of the CHR program has been limited due to lack of and use of an adequate reporting system on a nationwide basis. An adequate reporting system for all CHR programs is crucial because of the great variance among CHR programs. As an absolute minimum, the reporting system should produce accumulative data on each CHR activity by specific health care delivery function and area. This method will produce the accountability of the CHR program and still retain the program's flexibility at the Tribal level. Hard statistical data of this nature has never been utilized in justification of the program.
7. It is recommended that IHS explore analyzing statistics in terms of declines in mortality and morbidity that have occurred since the CHR programs began, particularly tuberculosis and infant mortality.
8. It is recommended that data collected by IHS be distributed back to the Tribes for their use and that IHS be responsible for providing meaningful interpretation of this data.

Recommendations Added at the Final CHR Task Force Meeting in Phoenix, Arizona

The National CHR Task Force Recommended:

1. That no more than 15% of CHR program resources be expended for administrative cost, both direct and indirect. Funding of direct administrative costs should have priority over indirect cost. Allowable administrative cost in excess of 15% should be secured from funding sources other than CHR program resources.
2. That an evaluation of the CHR program should be conducted in a manner that allows for measurement of its medical efficacy and cost effectiveness on a health care delivery function and area specific basis.
3. That the FY 1983 CHR contract and grant scopes of work be developed consistent with the health care delivery functions, areas, and settings as defined in the Assessment of Indian and Alaska Native CHR Program Resource Distribution's first report. All CHR program contract and grant scopes of work should be monitored to assure compliance with this recommendation.
4. That the second phase of the IHS/CHR program assessment project as described in the project summary dated April 25, 1982, be conducted as soon as possible. The second phase of the project will include a review of all 234 CHR program contracts with the primary objective of determining those health care delivery functions and areas to which they relate. It is expected that the base information gained through this phase of the assessment will be valuable in the future management and direction of the CHR program.

Close Out Session

The joint meeting of CHR Task Force members and CHR Association Representatives held their final work session November 4th. The group's morning activities consisted of completing and finalizing of the recommendations to be submitted to the Director, IHS. We were pleased to have Dr. Everett Rhoades, Director, IHS, attend a portion of the morning meeting to address the groups in this closeout session. Dr. Rhoades commented on the overall IHS program budget projections for FY 1983, including some of the critical health care delivery issues that the IHS and Tribal governments are currently experiencing. Dr. Rhoades discussed CHR effectiveness in providing essential health care services. Dr. Rhoades also stated that demonstrated effectiveness, accountability, and creditability will continue to be crucial elements for program justification and continuation.

Dr. Rhoades concluded by expressing his thanks to the Task Force and the Area participants for the work they are doing and stated that he would be looking forward to receiving the final report.

The two work groups spent the rest of the morning completing the recommendations for the final report. The meeting was adjourned with a prayer given by Priscilla Webb.

EXISTING INADEQUACIES IN HEALTH PERSONNEL, EQUIPMENT, AND/OR FACILITIES

The Aberdeen Area has a multitude of inadequacies when compared to accepted staffing methodologies for health care systems, the Joint Commission on Accreditation of Hospitals standards, and Health Care Financing, Medicare/Medicaid standards.

Attached are approved plans for correcting those inadequacies.

The barriers to accomplishing the aforementioned are:

1. Inadequate financial resources.
2. Inadequate full-time employment levels, i.e., ceiling.
3. Inability to utilize fully Medicare/Medicaid collections (Aberdeen Area collections were offset by \$739,000 in Fiscal Year 1983) to correct deficiencies.
4. Inappropriate appointment mechanisms for temporary positions, i.e., the restrictions on the use of term appointments to promote retention and recruitment.
5. Automatic data processing restrictions stifling systems development and creative efforts to facilitate efficiency and effectiveness in delivering health care.

The actions recommended for elimination of the above barriers are:

1. The restoration of full-time employment levels, pay raise and supplemental request, and the development of a budgeting process that will provide for cost of living increases commensurate with the private sector, i.e., accepted industry inflation figures.
2. The elimination of employment ceilings throughout the Indian Health Service.
3. That a Congressional mandate to cease and desist the offsetting of third-party collections be issued this year and be made a continuing instruction to the Department in further appropriation Acts.
4. Action taken to make the use of term appointments be made commonplace within the Indian Health Service to facilitate recruitment and retention.
5. That a model Service Unit (in the Aberdeen Area) be identified for the development of an automated health system (Medical Records, Supply, Financial Management, Payroll, Timekeeping, Patient Monitoring, Lab, X-Ray, Communications, Facility Monitoring, etc.). After the model is workable that it be replicated throughout Indian Health Service Hospitals.

IMPACT OF BUDGET CUTS TO IHS ON THE AVAILABILITY OF
SERVICES, PERSONNEL, TRAINING, AND PRIORITIES OF TREATMENT

The Aberdeen Area has been severely impacted by the budget cuts imposed on the Indian Health Service.

The attached summaries show the conditions Service Unit by Service Unit caused by budgetary shortfalls.

The end result of this condition is the rationing of care to Indian people within the Aberdeen Area. Further evidence of the rationing situation is the backlogs in the dental, mental health, eyecare, and unmet surgery areas.

Special attention must be given to these grave situations in the Aberdeen Area, which currently only remain functional because of what one could term heroic efforts by physicians and support staff at all twelve Service Units. Examples are working long hours without compensation, doing two jobs or doing the work of two people as evidenced by CAP Lab productivity data, etc.

Budget cuts have hit the Aberdeen Area hard and recovery will take at least six to eighteen months. New staff will have to be recruited, services that have been eliminated reinstated, and predictability re-established.

Please consider the attached summaries in deliberations regarding funding and resource allocation.

PROGRAM ADJUSTMENTS
BELCOURT SERVICE UNIT

I. Positions Vacant: 10 Value: \$174,207

II. Services Reduced:

1. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
2. Budgetary restraints have required the reduction in ambulance, x-ray and housekeeping services due to overlapping functions.
3. Ambulance program is basically non existent.
4. Payments for eyeglasses are restricted to school age children one time only.
5. Outpatient mental health treatment is backlogged and a waiting list exists due to budget constraints.
6. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
7. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

PROGRAM ADJUSTMENTS
EAGLE BUTTE SERVICE UNIT

I. Positions Vacant: 16 Value: \$428,043

II. Services Reduced:

1. There is a reduction in the number of services available and complexity of services rendered because of four medical officer vacancies.
2. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
3. Payments for eyeglasses are restricted to school age children one time only.
4. Ambulance program is in need of two ambulances and a lift or they will be required to constrain services.
5. The State Infant Child Health Program has pulled out because of termination of the grant.
6. The overall health status, i.e., supervision of Physician Assistants, school health, field health, specialty clinics, etc., are failing because of the unavailability of permanent medical staff.
7. The high number of vacancies has caused morale to decline to a serious state, affecting patient care.
8. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
2. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.
3. South Dakota has declared IHS the first payor by State law, thus creating an enormous demand for increased services, i.e., renal dialysis.

PROGRAM ADJUSTMENTS
FORT BERTHOLD SERVICE UNIT

I. Positions Vacant: 6 Value: \$163,296

II. Services Reduced:

1. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
2. Payments for eyeglasses are restricted to school age children one time only.
3. Direct Ambulance Program has been terminated and ambulance services contracted out on a per trip basis.
4. Twin Buttes, White Shield, and Mandaree Clinic services have been cut because of medical officer vacancies.
5. Previously donated clinic space is now only available on a rental basis causing inconvenience and reductions at Parshall.
6. The Minne-Tohe Health Center has been closed on occasion because of lack of staff.
7. The overall health status, i.e., supervision of Physician Assistants, school health, field health, specialty clinics, etc., are failing because of the unavailability of permanent medical staff.
8. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

PROGRAM ADJUSTMENTS
FORT TOTTEN SERVICE UNIT

I. Positions Vacant: 5 Value: \$109,905

II. Services Reduced:

1. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
2. Payments for eyeglasses are restricted to school age children one time only.
3. The unavailability of resources required to implement a community injury control program has resulted in the deaths of four children and possibly one adult due to home fires.
4. The TB surveillance program has been jeopardized because of CHN and CHR staff deficiencies due to budget constraints.
5. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
6. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

PROGRAM ADJUSTMENTS
FORT YATES SERVICE UNIT

I. Positions Vacant: 11 Value: \$338,135

II. Services Reduced:

1. A general decline in quality, number of services rendered, competency of care and continuity of care has resulted because of the unavailability of medical staff since mid May of 1982.
2. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
3. Payments for eyeglasses are restricted to school age children one time only.
4. The McLaughlin Health Center operates only intermittently because of the lack of direct care providers at Fort Yates, causing all available providers to be required to provide service at Fort Yates.
5. The OB contractor has requested a doubling of the cost of the contract with no increase in service. The contractor is unable to consistently provide specialty obstetrics or initiate surgical support.
6. Cannonball, Bullhead, Wakpala, Little Eagle, and Shields have been all but eliminated.
7. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
8. Due to inadequate nursing staff, there is reduced nursing coverage on evening and night shifts.
9. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

PROGRAM ADJUSTMENTS

PIERRE SERVICE UNIT

I. Positions Vacant: 6 Value: \$153,531

II. Services Reduced:

1. Owing to the lack of funds to maintain the facilities, the clinics have had to close down several times a month.
2. Poor road conditions have placed an additional strain on the services because of increased travel time and financial resources needed to travel to the clinics.
3. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
4. Payments for eyeglasses are restricted to school age children one time only.
5. Mental health and social services are non existent because of staffing and budget problems.
6. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
7. The State of South Dakota has decreased alcoholism funding, causing an increased burden on IHS resources (see Dr. Nutting's study, Winnebago).
8. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

PROGRAM ADJUSTMENTS
PINE RIDGE SERVICE UNIT

I. Positions Vacant: 22 Value: \$605,000

II. Services Reduced:

1. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
2. Payments for eyeglasses are restricted to school age children one time only.
3. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
4. Due to a shortage of Nurses, they have reduced to 49 beds. There is not regular nursing coverage of the Pediatric Unit.
5. Social admissions due to declining third party resources have further restricted acute care beds causing additional resource strains on CHS and an inability to take care of more appropriate admissions.
6. The operating room staff shortage causes it to operate intermittently.
7. The crippled childrens clinics on site have been reduced, especially neurology.
8. Water fluoridation has been discontinued due to funding.
9. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHF program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

PROGRAM ADJUSTMENTS
RAPID CITY SERVICE UNIT

I. Positions Vacant: 12 Value: \$241,922

II. Services Reduced:

1. CHS reduced to priority 1 - funding available for 32 weeks of FY-83 39% shortfall, assuming there are no catastrophic cases. The shortfall at Rapid City is even greater because of the specialties of the medical staff and the specialists available in the community which attract the more difficult cases.
2. The Rapid City Regional Hospital will only accept top dollar for care rendered, i.e., price not cost or any variation thereof, thereby causing additional budgetary problems.
3. Payments for eyeglasses are restricted to school age children one time only.
4. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
5. Because of its favorable location, the Rapid City Area is attracting an increasing number of Indian medical indigents requiring care. An increase of 12.3% in outpatient visits alone has been noted, and the inpatient area has been totally full several times causing CHS strain.
6. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.
5. Yellow Thunder Camp, a new Indian settlement in the Black Hills, is creating additional CHS strain. These thirty to forty families are requiring both outpatient and inpatient services, and about \$75,000-\$100,000 of Contract Health Services.

PROGRAM ADJUSTMENTS

ROSEBUD SERVICE UNIT

I. Positions Vacant: 8 Value: \$227,818

II. Services Reduced:

1. CHS reduced to priority I - funding available for 32 weeks of FY-83 39% shortfall, assuming there are no catastrophic cases.
2. Payments for eyeglasses are restricted to school age children one time only.
3. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
4. The Community College Nursing Program has closed causing a nursing shortage and requiring the restriction of care.
5. There is a large number of career patients at Rosebud occupying bed space because a long term care facility is not available. These same patients are utilizing staff time that could be directed toward more acute situations now being sent out on Contract Health Services.
6. Satellite clinics have been closed at Norris, White River, Wood, Okreek, and some times Winner because of budgetary constraints.
7. The number of school nurses have been reduced by local school boards causing additional IHS workload.
8. Water fluoridation has been discontinued due to funding.
9. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in Medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.
5. The crippled childrens clinics on site have been reduced, especially neurology.

PROGRAM ADJUSTMENTS

SISSETON SERVICE UNIT

I. Positions Vacant: 6 Value: \$135,865

II. Services Reduced:

1. Sisseton's available Nursing Staff was unable to handle the complexities that the medical staff wanted to admit, causing extra CHS utilization. Nursing Staff can only cover 18 of the 26 available beds.
2. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
3. Payments for eyeglasses are restricted to school age children one time only.
4. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
5. Decreased availability of WIC has made Indian Health Service provide services less accessible.
6. No clinics at Enemy Swim and Old Agency. Services have also been reduced at the Wahpeton and Flandreau satellites.
7. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

PROGRAM ADJUSTMENTS
WAGNER SERVICE UNIT

I. Positions Vacant: 5 Value: \$ 91,527

II. Services Reduced:

1. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
2. Payments for eyeglasses are restricted to school age children one time only.
3. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
4. Clinics at Santee, Nebraska, have been discontinued.
5. The unavailability of WIC services again cause IHS services to be constrained.
6. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

PROGRAM ADJUSTMENTS
WINNEBAGO SERVICE UNIT

I. Positions Vacant: 8 Value: \$171,241

II. Services Reduced:

1. CHS reduced to priority I - funding available for 39 weeks of FY-83 25% shortfall, assuming there are no catastrophic cases.
3. Payments for eyeglasses are restricted to school age children one time only.
4. The high number of vacancies caused morale to decline to a serious state, affecting patient care.
5. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in medical procedures and processes, and a general deprived state for employees.

III. New Service Demands Because of Other Third Party Reductions:

1. BIA and State reductions in the provision of nursing home care have increased the demands on the inpatient staff and facilities.
2. IHS staff face increasing health care demands, previously fulfilled by the CHR program due to CHR reductions.
3. Counties are restricting the eligibility or creating barriers to reduce Medicaid accessibility, causing increased demands for health care.
4. Block grant reductions and the lack of accessibility are having a trickle down effect causing increasing demands on IHS staff and facilities.

ABERDEEN AREA OFFICE
AND TOTAL ABERDEEN AREA

I. Positions Vacant:	Aberdeen Area Office - 26	Value:	\$ 800,019
	Aberdeen Area Total - 155	Value:	\$3,499,805

II. Services Reduced:

1. Travel by Area consultants to service units and continuing education is reduced causing a decline in quality of care.
2. Consultants or program managers doing several jobs, i.e., two Area Office jobs, plus direct patient care to alleviate service unit crisis.
3. The lack of finances to repair and maintain housing and health care facilities, causing recruitment and retention problems and additional budgetary problems.
4. There are 10 projected Service Unit physician vacancies July 1, 1983, due to the compilation of difficulties.
5. Maternal Child Health consultation is non existent because of an unfunded vacancy.
6. Total funding of Contract Health Services on a priority one status will only meet 39 of the 52 weeks assuming no catastrophic cases. We are currently averaging one catastrophic case a month. This will only cause additional shortfall.
7. Training in the Aberdeen Area is at an all-time low, resulting in low morale, inability to stay current with the state of the art in medical procedures and processes, and a general deprived state for employees.

PROBLEMS RELATED TO PL 93-638

The contracting of programs to Tribes under PL 93-638 is increasing immensely in the Aberdeen Area. With the increase in contracting, the following problems are coming to the forefront:

1. There is inadequate indirect cost money to support the contracts and grants with Tribal governments. This results in the reduction of services because the indirect cost must then come from the Hospitals and Clinics account or other services accounts.

The other alternative is not supporting the normal cost of Tribal government by not allowing or convincing Tribal government not to accept indirect costs.

2. The programs Tribes are accepting are poorly funded, sometimes less than 50% funded.
3. The requiring of Tribes to adhere to strict cost accounting methods and budget activities is contrary to the flexibility needed to operate health programs. This flexibility exists in the Indian Health system because of its size and the ability to transfer funds from one Service Unit to another. Flexibility also exists after the year end in that funds can be deobligated and used to satisfy any claims, not just those claims in a certain budget activity.

These problems are not insurmountable, but need attention to facilitate the turning of programs over to Tribes. Some alternatives are:

1. The appropriating of funds to support the normal cost of contracting with Tribes. This would serve as an inducement to Tribes to contract and manage their own programs. The Aberdeen Area requires about \$1,500,000 in additional Tribal Management funds to support the contracting process.
2. Attention must be given to supporting the Indian Health Service base program. The base program has been eroded by inflation and now requires additional support to keep pace with needs and demands placed on it by constituents. Tribes will not and should not be allowed to accept programs that are doomed for failure because of inadequate resources.
3. Certification of the PL 93-638 regulations is necessary to allow for necessary flexibility and creativity in program management and development. That is, Tribes after proper request should be allowed to use funds from one budget sub-activity for another as long as they are fully meeting the program requirements set out in the contract for the budget subactivity from which funds are transferred.

UNMET NEEDS FOR WATER AND SANITATION FACILITIES

The construction of water and sanitation facilities is perhaps the most important link to continued improvement in the health status of American Indians.

The program to continue this progress, however, must be adequately supported in three areas - construction, operations, and maintenance.

Attached is a self-explanatory summary of those construction unmet needs for the Aberdeen Area.

The construction of these facilities will serve to decrease outpatient visits and inpatient days for Diseases of the Respiratory System, Diseases of the Skin and Subcutaneous Tissue, Diseases of the Digestive System, to name a few. These are four of the top ten outpatient visit diagnoses and five of the top ten causes for admission to hospital that could be minimized by adequate water and sanitary facilities. This means that those resources currently being used for this kind of care can be diverted to other conditions thus having a domino effect on improving the status of Indian health.

Sanitation Facilities Construction Services

The Sanitation Facilities Construction program as authorized by PL 86-121 constructs sanitation facilities for Indian homes and communities within the Aberdeen Area. Between 1960 and 1982 a total of \$63,682,175 involving 299 projects has been allocated the Aberdeen Area for this purpose. The construction has provided water and/or sewer first service to a total of 12,425 homes. An additional 5,574 homes received upgraded facilities or improvements to facilities which were already existing at the time of the project construction. Community facilities conforming to applicable engineering standards and the special needs of the reservations have been constructed in virtually every significant grouping of homes within the Area.

Yet despite the significant construction accomplishments, considerable facilities remain to be provided for the health needs of the Indian people. In 1982, 11 requests for assistance were received from the Tribes. The BIA FY 82 consolidated housing inventory shows 1,692 housing units in substandard condition, a need for 2,112 new homes, and a need for 667 housing unit renovations. Needed sanitation facilities for these homes normally should be provided under PL 86-121 - Housing funds.

The Area has currently identified unmet needs for PL 86-121 - Regular projects (existing homes, capital improvements, solid waste, etc.) totaling \$25,216,000. This will represent first service to 649 homes and provide communities with system capital improvements, establish solid waste systems, etc. Except for two special Congressional appropriations (Standing Rock - FY 79 and Turtle Mountain - FY 80) no regular PL 86-121 funds have been received since FY 77.

The third category for PL 86-121 is for special or emergency projects. Except for one project at Pine Ridge, no funds have been received by the Area for these type of situations since FY 78. Although obviously emergencies cannot be predicted, it would seem unlikely that additional requests for assistance will not be received.

The Sanitation Facilities program is a co-operative program with the Indian Tribes. Since 1961, the individual Tribes and others have contributed \$3,768,237 toward the construction of their facilities. Tribal governments, organizations, and individuals are continually involved in the development and construction of the projects. In FY 82, construction by the Tribes or Indian contractors amounted to \$537,750 of the total \$1,020,079 constructed awarded.

A	Below Minimal, Individual System, First Time Served
B	Above Minimal, Community System, First Time Served
C	Below Minimal, Individual System, First Time Served
D	Above Minimal, Community System, First Time Served
E	Below Minimal, Individual System, Previously Served
F	Above Minimal, Community System, Previously Served
G	Operation and Maintenance Organization
H	Below Minimal, Individual System, Previously Served
I	Above Minimal, Community System, Previously Served

UNMET NEEDS PRIORITY LIST

ABERDEEN AREA

PRI	SFCODE	ORGID	SFNAME / ORGNAME	PH	WATER	SEWER	SOLID	QUM	COST	CUMULATIVE COST
013	4590457	1017LT	LONG HOLLOW	01	F				20,000	
053	4590465	1011FL	FLANDREAU IND SCH	01	DE	D			55,000	
043	4590471	1015PR	WAMBLEE	01	F	F			55,000	
033	4590474	1015PR	KYLE	01	F	F			100,000	
030	4590475	1015PR	PINE RIDGE VILLAGE	01	F	F			100,000	
001	4590480	1015PR	OGALA	01	B	F	A		408,000	
033	4590481	1015PR	ALLEN	01	F	F			20,000	
048	4590484	1015PR	WAKPANI	01	F	F			125,000	
031	4590488	1016B3	PARKLEE	01	F	F			80,000	
053	4590493	1016B3	OKBEEK	01	F	F			80,000	
051	4590494	1016B8	ROSEBUD	01	F	F			144,000	
044	4590498	1016B3	MILKS CAMP	01	F	F			115,000	
074	4590499	1016B3	ST FRANCIS HUD HOUSING	01	F	F			100,000	
036	4590510	1018S8	WAKPALA/CHIEF GAUL INN	01	F	F			100,000	
031	4590513	1016B8	UPPER CUT MEAT	01	F	F			205,000	
015	4590518	1014CC	BAD NATION	01	F				150,000	
									\$25,216,000	

74

Above Minimal, Individual System, First Time Served A
 Above Minimal, Community System, First Time Served B
 Minimal, Individual System, First Time Served C
 Minimal, Community System, First Time Served D
 Above Minimal, Individual System, Previously Served E
 Above Minimal, Community System, Previously Served F
 Operation and Maintenance Organization G
 Minimal, Individual System, Previously Served H
 Minimal, Community System, Previously Served I

THE IMPACT OF COMPETITIVE BIDDING ON THE QUALITY OF
AND ACCESS TO HEALTH CARE IN THE ABERDEEN AREA

The quality of and access to health services will be seriously compromised in the Aberdeen Area if competitive bidding requirements are fully implemented.

The concept that all services are the same as far as quality and acceptability would go against historical referral patterns and be contrary to physician preferences for tertiary care, impairing relationships with colleagues with whom they are familiar with and with whom Indian people have established a continuity of care relationship. This would inevitably result in a lesser quality of care for Indian people.

The use of competitive bidding process should be left to the Area Chief Medical Officer, whereby he or she can exercise judgment regarding the issues of quality, access, acceptability, etc.

This would allow for the negotiation of contracts that result in the stabilization of quality, of referral patterns, of continuity of care and confidence in the IHS system. That is, specialists would be seeing the same client on a continuing basis. This is certainly the most desirable situation from both the provider and client perspectives.

Other non-quality issues that would become problems are: the cost of travel to care is becoming prohibitive, the use of generic supplies to decrease cost (also decrease patient acceptance), the lack of patient compliance (patients not keeping appointments) resulting in increased cost due to complications, and the general decline in the ability of the IHS system to meet patient acute care needs due to a demise in current patterns and relationships which support a preventive family care oriented system.

TASK FORCE ON CHS TO THE DIRECTOR, IHS COMMENTS

In response to the request for a critique of the report of the Director's Task Force on Contract Health Services, which presents a large number of recommendations on a wide variety of issues, comment is difficult without risking offending those who obviously put a great deal of effort and thought into the report. We have a great deal of respect for those members of the Task Force with whom we're acquainted, but we frequently find our way of thinking and problem solving in conflict with others and must hope that our comments will be accepted in the spirit in which they are intended. We have attempted to comment honestly and boldly.

The breadth of the report makes comment difficult, as the report offers no consistent organizing principle. Seeing no other alternative, comments here will be divided into general and specific categories, and comments in the specific category will be presented in the order of recommendations appearing in the report. It should be noted that our comments are positive as well as negative.

GENERAL COMMENTS:

1. The broadest comment that we would make about the report is that it recommends sweeping and substantial changes in policy and operation without either clearly defining the problem or problems to be corrected or stating the objectives and expected outcomes of the recommended actions. This approach seems rather like a physician prescribing a course of treatment for a patient before he has diagnosed the patient's disease or identified the goals of therapy.
2. A comment related to the first is that the report does not give evidence that a clear and consistent problem-solving methodology was adopted by the Task Force. There are many approaches to organized problem-solving, but it seems appropriate to note that the substance of organized problem solving in organizations is remarkably similar, focusing on:
 - a. A statement of the guiding principles of the organization;
 - b. A statement of the current status of the organization;
 - c. A statement of the desired status of the organization;
 - d. A statement of the means of bridging the gap between b. and c. which is consistent with the principles established in a.;
 - e. A statement of the expected results of implementing d., of a mechanism for measuring the actual outcome of d. and for feeding this information back to the organization so that further corrective action may be taken.

The report of the Task Force appears to jump into the problem-solving method at step d. and then to jump out again without dealing with the other steps. Certainly action plans developed in the manner of the Task Force may be adopted and implemented. Action plans of this sort may even succeed. However, we think we are observing in IHS the increasingly common experience with such plans: (1) that they do not succeed and, which is worse, that the organization does not understand why they do not succeed, or (2) that they may appear to succeed in solving one problem while creating other and perhaps worse problems. Not recognizing that the plans were flawed, we seek explanation for failure in "lack of support", "lack of resources", "lack of time", etc.

SPECIFIC COMMENTS:

1. Terminology

The Task Force proposes the development and adoption of a precisely defined terminology to be used by the IHS. This is a laudable, though not easily achieved objective. IHS would surely benefit from an examination of its own use of terms and the correction of what seems to us such errors as identifying primary care as a type of health service when in fact it refers to a level of service (primary, secondary, tertiary) and means that level of health service, whether educative, preventive, curative, or rehabilitative in type, which is most accessible and affordable to individuals in their homes and communities, which we discussed more thoroughly in our paper on comprehensive primary health care.

2. Programmatic Reorientation

This is, without a doubt, the most important recommendation of the Task Force, yet the report fails to indicate how this might be accomplished. The Task Force seems to suggest that no more than "willingness" to support is required. Will certainly is a factor in such a reorientation, though the adoption of a well-defined problem-solving approach, as outlined under the General Comments, and the attention to detail, as suggested by the first recommendation of the Task Force, are equally significant. What is not apparent in this recommendation is an awareness of the role played by management in the shaping of the orientation of the organization or in the transformation of the orientation into a set of actions. If there is to be a reorientation, all levels of management of IHS will need to be involved to an extent frequently resisted in the past.

3. Eligibility for IHS Services

The Task Force recommends that eligibility for IHS services be clearly defined and restricted to persons who are of Indian descent, who are members of Federally recognized Tribes, who live within a health service delivery area, and formally enroll for IHS services. The Task Force asserts that "limited funding for IHS clinical services" requires this restriction but offers no evidence to substantiate this assertion. Neither does the Task Force indicate the extent of relief that would be realized nor any other measure that would lead to a conclusion that such an action is required or would be an appropriate, effective, adequate, or efficient means of relief.

Beyond the shortcomings of the Task Force recommendations on eligibility, the presentation of legal background contained in the recommendation is not accurate. The legal base for current IHS eligibility criteria is found in the Snyder Act (25 USC 13). The regulations found at 42 CFR 36.12 and 42 CFR 36.23 represent the current interpretation and application of the Snyder Act (the law) by the agency. The Task Force states that the current eligibility criteria are ambiguous and insinuates that they are neither clear nor objective. In fact, this is not the case as the regulations at 42 CFR 36.12 provide detailed and specific instructions to be followed in establishing eligibility for direct care and the regulations at 42 CFR 36.23 refer to and extend the criteria found at 42 CFR 36.12 for the purpose of establishing eligibility for contract health services.

It appears to us that what the Task Force should have said, but didn't, was simply that the Task Force didn't like the eligibility criteria because they are broad (rather than ambiguous) and that the Task Force believes that eligibility criteria should be more restrictive (rather than more objective).

In order to further evaluate the eligibility recommendations of the Task Force it is necessary to examine the intent of Congress in establishing the Indian Health Service and to review relevant court decisions.

The Snyder Act (25 USC 13) states, in part:

The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes: (emphasis added).

It is important to note that the term "Indians" is not defined in the Act and is not defined in the issues of the Congressional Record which contain transcripts of the debate on the Act. As the Congress of the United States has not developed a general-purpose definition of the term "Indian", and as Congress typically defines Indian for the purpose of each Act it passes which deals with Indians, it would appear, at first glance, that we are indeed faced with an ambiguous situation. However, if it is understood that the Snyder Act was passed in order to correct a procedural problem faced by the House, i.e., appropriation bills not backed by an authorization act could be challenged on the floor of the House through a point of order as lacking general statutory authority, then it may be recognized that the language of the Act must be necessarily broad to accommodate the intent of Congress into the future without requiring frequent changes of authorization legislation. The purpose of the Authorization Act notwithstanding, it must also be clearly understood that, barring a more restrictive definition of "Indian" incorporated into an individual appropriation act, the Bureau of Indian Affairs and the Indian Health Service are required to apply a broad definition of eligibility, as, after all, the Snyder Act does simply say "the Indians throughout the United States."

This is not to say, however, that services must be provided to all Indians wherever they may be. On the contrary, the United States Supreme Court held in *Morton v. Ruiz*, 415 U.S. 199, 230 (1973), that the Secretary of the Interior and by extension the Secretary of Health and Human Services has authority "to create reasonable classifications.... in order to allocate the limited funds available...."; that as long as such standards are rational and proper, developed through appropriate rulemaking procedures, and applied consistently without bias, these standards "might leave some of the class otherwise encompassed by the appropriation without benefits." *Morton v. Ruiz*, 415 U.S. 231 (1973).

Where then does all this lead us?

- A. The Snyder Act says that the moneys appropriated by Congress are to be used for the benefit, care, and assistance of the Indians throughout the United States;
- B. The current regulation governing eligibility found at 42 CFR 36.12 conforms to the intent of the Snyder Act and specifically indicates criteria to be considered in judging eligibility;
- C. A more restrictive definition of "Indian" for the general purposes of IHS has not been established by Congress;
- D. A justification for limiting the population to whom services are to be provided has not been developed by the IHS.

What should be done?

- A. The IHS should proceed to evaluate its current position for the purpose of demonstrating objectively through epidemiologic measures the health care needs of "the Indians throughout the United States" and the extent to which IHS may respond to these needs. It should be noted that RAC or RRM projections are not acceptable for this purpose.
- B. From the foregoing analysis IHS should develop criteria, programmatic in nature, which would both relieve IHS from the pressure to provide all things to all Indians and, most importantly, would avoid the debilitating and destructive argument over the definition of the term "Indian" for the purposes of IHS and remove the need for divisive concepts such as "on or near".
- C. Lastly, IHS should require that an Indian be registered with IHS to be eligible for services. However, a registration drive should only be conducted after a demographic information study has been conducted and accepted and basic decisions regarding information management, such as unique identifier, data base vs. file-management computer systems, telecommunication, etc., have been made.

4. Uniform Eligibility Requirements

The Task Force Report argues for uniform eligibility requirements. This is an excellent idea which is consistent with the suggestions made in the preceding section.

5. Clinical Priorities

The Task Force report argues for the establishment of clinical priorities. This is an excellent idea and is consistent with the suggestions made in Section 3 with the difference that the clinical priorities thus become additional and powerful, though perhaps unacknowledged, determinants of eligibility. Because of the powerful potential of these clinical priorities, for good or ill, much more thought and discussion should be devoted to this issue. By focusing on prioritization of specific services (such as the list of services for Acute and Life-Endangering Illnesses), individual eligibility or exclusion will be determined on the basis of diagnosis and treatment determinations, which presumes that the individual, expecting care, may already be in one of our facilities or a contract facility, for such a determination to be made. By focusing on prioritization of levels of care, services are provided that pertain to the whole eligible population, without the necessity of having to make a determination of eligibility or exclusion within that level. As we describe in our primary care paper, "primary"

specifies a level of care. It is difficult or impracticable to limit accessibility to services within a level, e.g., selected primary care services, whereas limits are more effectively, and to some extent, self-applied between levels, e.g., between a primary care provider or facility and another facility providing secondary and/or tertiary care. Offering primary but not secondary or tertiary care effectively limits services that can be provided, without at this point having to make a determination of eligibility or exclusion. Limits to secondary and tertiary levels of care, if provided, can then be approached through further careful definitions of levels of care, types of services, and priorities.

Thus, we would suggest that the priorities statement be altered somewhat as follows:

- A. Primary Care and Selected Health Promotion and Disease Prevention Measures. We would avoid the word "proven", insofar as many primary care measures are not proven and the word implies invidious comparison.
- B. Selected Secondary Care. Care of acute and life-endangering illnesses would be included under A. and B., to the extent that such services can be provided at these two levels.
- C. Tertiary, Chronic Maintenance, and Support Services.
- D. Experimental, etc.

There will be great difficulty in defining and clarifying these concepts appropriately and adequately and then translating these abstractions into a set of implementation steps, but the problem so defined can be solved consistently with the guiding principles of IHS, there are individuals in IHS capable of solving such a problem, and such a solution holds the best hope for epidemiologically-based problem-solving health planning within IHS.

6. Clinical Resource Allocation

The Task Force Report suggests a formula to be used to determine resource distribution that depends more on the size of the population to be served than the epidemiology of the population to be served. This formula should be altered so that epidemiologic rather than administrative data are the driving factors.

7. Service Delivery Areas

The Task Force recommends that "on or near" residence requirements be applied to direct as well as to contract services. IHS has not demonstrated a need for such a restriction nor a rationale which is consistent with the Snyder Act. The adoption of a system of eligibility based upon clinical priorities as described above would obviate the need for such restrictions and most importantly would encourage the development of Indian people rather than pressure them to remain on the reservation because that is the only place they can afford to live.

8. Procurement Policy

The Task Force recommendations on procurement seem appropriate.

9. Payment Policy

The Task Force recommendations on payment policy, third-party resources, and fiscal intermediaries seem appropriate.

10. Social Security Numbers

The Task Force recommends that use of third party resources be maximized seems appropriate. Use of the Social Security number as a unique identifier is not appropriate.

11. Emergency CHS Notification

The Task Force recommends that the current 72 hours emergency CHS notification limit be reduced to 24 hours. This recommendation is not justified, neither does this seem necessary or appropriate. The recommendation would not appreciably alter transferral rates from contract to IHS facilities and only would have punitive effect upon the victims of emergencies.

12. Information Management

The Task Force recognizes that the recommendations contained in the report cannot be successfully implemented without an appropriate, effective, adequate, and efficient information management system. This is patently true. It should be noted that the development of such an information management system, whatever other recommendations are chosen, will also have an effect on setting limits to services, which will then be more realistically related to the epidemiological, demographic, and geographic characteristics of the population served.

ELEVATION OF THE POSITION OF THE DIRECTOR OF THE INDIAN HEALTH SERVICE TO THE LEVEL OF AN ASSISTANT SECRETARY IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The notion of elevating the status of Indian Health within the Department of Health and Human Services is not new. It was suggested by the now Director of the Indian Health Service back in 1975 and 1976.

The benefits of such an arrangement would be:

1. Better coordination of all services rendered to Indian people by the Department of Health and Human Services.
2. Administrative white tape that currently overburdens the relationships in the Department can be eliminated (HRSA, PHS, etc.).
3. The multitude resources that the Department has could be brought to the aid of and coordination of health services for Indians thus relieving Congressional Committees of inefficient activity resulting from that lack of coordination.
4. A comprehensive health benefits package could be constructed for Indian people by the Department that would cross several areas and be funded by several different sections of the Department (NIAAA, NIODA, HICFA, etc.) creating efficiency and effectiveness in the Department in dealing with the status of Indian health.

In short, the total resources of the Department should be brought to bear on the problems of Indian Health Service. This does not seem possible unless the Indian Health Service is high enough in the Department to coerce this kind of cooperation needed to help Indian people elevate their health status.

It is recommended that Congress commission a General Accounting Office study to determine the feasibility of a plan to elevate the status of the Indian Health Service within the Department.

SUMMARY OF THE PLANS FOR THE USE OF
ABERDEEN AREA MEDICARE/MEDICAID FUNDS FOR
FISCAL YEAR 1983

Revised 5/26/83
AAO-MCE

Name of Facility	No. of Personnel	Personnel Costs	Equipment Costs	Supply Costs	Facility Alteration Contracts	Contracts Other Than Fac. Alter.	Total \$ Requested	Recurring Costs	Non-Recurring Costs
Belcourt	8	\$ 125,400	\$ 152,300	\$27,300	\$ 356,300	\$ 241,955	\$ 903,255	\$ 393,855	\$ 509,400
Eagle Butte	12	236,200	14,785	1,000	752,000	135,346	1,130,546	372,546	758,000
Fort Berthold	7	109,300	32,259	3,000	12,000	96,700	246,700	207,000	39,700
Fort Thompson/ Lower Brule	11	201,300	27,400	5,000	130,000	109,600	469,300	286,500	182,800
Fort Totten	4	62,000	16,000	500	12,000	119,708	210,208	182,208	28,000
Fort Yates	13	222,400	25,000	2,000	248,500	266,204	764,104	489,604	274,500
McLaughlin	5	102,400	10,000	2,300	37,000	65,100	216,800	168,800	48,000
Pine Ridge	27	512,300	28,635	800	57,500	394,817	989,417	903,417	86,000
Rapid City	18	212,100	55,050	24,450	603,125	255,316	1,008,541	370,816	637,725
Rosebud	18	329,550	272,144	500	847,500	304,988	1,728,282	610,538	1,117,744
Sisseton	13	280,000	102,200	1,300	762,300	203,378	1,348,478	484,678	863,800
Wagner	13	227,600	27,405	2,000	87,000	201,855	545,860	419,455	126,405
Wanblee	3	44,500	70,000	300	153,380	61,000	329,180	105,800	223,380
Winnipeg	11	136,000	296,882	2,750	231,600	225,715	853,165	362,615	490,550
TOTALS	154	2,801,050	1,130,060	73,200	4,290,205	2,681,682	10,976,197	5,480,732	5,495,465

Senator ANDREWS. You know, when you cut out somebody's travel allowance and perquisites and all that, then they have a tendency to quiet down. They get too harassed.

I remember a fellow by the name of Dan Rooney. He was a delightful attorney. He was first to go on the Appropriations Committee and we got in a major set-to with the Bureau of Standards. Dan found that they had recommended a \$57,000 flagpole. Mind you, this was 17 years ago. We spotted it. Do you know, they lost their typist; they lost their chauffeur's limousine; they lost a whale of an awful lot of things; and they got the message and I think that it is still worth it pretty well. Getting the attention of some of those high muckety-mucks that it is rather difficult to get to from time to time.

Mr. Buckanaga, we have your statement in the record. Would you like to summarize it?

STATEMENT OF JOHN BUCKANAGA, DIRECTOR, BEMIDJI INDIAN HEALTH SERVICE PROGRAM

Mr. BUCKANAGA. Just a few comments, Senator.

The Bemidji area, which encompasses the States of Wisconsin, Michigan, and Minnesota, is primarily an area that has been terminated in a sense in the 1950's and 1960's. Through the auspices of the Office of Economic Opportunity programs we have been able to restore some opportunity in all aspects of socioeconomic conditions to the Indian people. In the 1970's, Public Law 93-638 and the Indian Health Care Improvement Act gave us another vehicle to transfer Federal funds to Indian tribal governments through contract procedures. We then initiated a health delivery system for those tribes with their cooperation and participation. Today we have 17 tribes in those three States that manage their own health care and it makes it rather—I am not saying easy, but rather comfortable in a sense that they cannot criticize us because they are the ones that are managing their own health care.

The problems we have in the delivery of health care services is the contract health care dollars that are limited to us by congressional appropriation. I think that is a problem occurring today in terms of the Dakota areas. It is very difficult to manage a program when you have an earmarked dollar amount of contract health care dollars and cannot meet all the needs as expressed by the tribes from the Dakotas here.

We have some of that problem but utilizing every possible resource, State resources, third party, private insurance, whatever we can scrounge, we then do enforce the policy of the law that Indian health is the last payor, the last resort to pay the bills. We have been fortunate to have good cooperation with the tribes, and good cooperation from the State governments in utilizing legislation that is available to all citizens and particularly Indian people.

However, recently the Congress has cut back the budget in the funding process and as a result we anticipate that the State will cut-back on us. They set their priorities a little bit higher which means this x number of Indian people who need the program will not get it. We do not have any direct care facilities in the State of Michigan as

an inpatient facility. We do not have any of those in Wisconsin, although in the 1950's we had two in Wisconsin. We had two that were closed up also in Minnesota because of Federal legislation in the 1950's, but again we have restored services with dollars available to us.

And I do want to emphasize that there is a constant need for additional dollars. We have to buy our services.

I would like to also emphasize that the contract health care program that we have is a very difficult program in terms of dealing with private vendors. We are almost at their mercy in terms of paying all the bills that they charge us with.

We had an editorial in a newspaper this Wednesday, or this week, the Minneapolis Tribune, where they were talking about small town doctors. We are subject to a lot of them and the editorial gave us some horror stories and illustrations of a physician treating people, in this case an Indian person, who diagnosed gallbladder and operated and they did not find anything wrong with the gallbladder. It was just ridiculous, the whole thing. The end result was that the patient stayed in the hospital more days than he should have, and the doctor bill and the hospital bill and other bills that go along with that were tremendously high, and the townspeople, and the community praised the doctor for creating the hospital, creating jobs, and getting more funds into those villages.

These are the conditions that we must face in contract health care. However, again we have no other recourse. We are trying to do the best we can with what we have and again we emphasize that there is a need for contract health care dollars for our area.

Senator ANDREWS. Ms. Robertson said a minute ago that she estimated that there was about a 50-percent shortfall in personnel. Your shortfalls carry over to contract health care probably as much as personnel. What is the shortfall you would estimate, percentagewise, between the needs and what you have?

Mr. BUCKANAGA. We projected in our documentation that there is needed almost \$10 million of which \$6.5 million would be to upgrade facilities, health centers, clinics, outpatient facilities, and the remainder would be for staffing to adequately deliver health services and health care.

Senator ANDREWS. So you are looking at about the same 50-percent shortfall?

Mr. BUCKANAGA. Yes.

Senator ANDREWS. What impact does the implementation on April 1, of the competitive bidding system, have in your service area?

Mr. BUCKANAGA. We had just one problem with it that, I can remember, but it really was not a problem of the legislation. I think it was a problem on the part of the vendor not properly reading the paper that we submitted to them and not submitting a request for the contract.

Senator ANDREWS. What has been your experience in the Aberdeen area on this? What impact has the implementation of competitive bidding had in your area?

Ms. ROBERTSON. We have very little on it. Essentially, we have non-responsive bidding. We did look at the A-76 process and that business. There was some talk that the dental clinic in Rapid City could be done

much cheaper than we do could do it. That turned out not to be the case after cost analysis. There is no impact on us.

Senator ANDREWS. Do you anticipate the closing of many hospitals in your service area as a result of competitive bidding or for any other reason?

Ms. ROBERTSON. The only reason I would have to close a hospital is, if I did not have the quality figures and facts there, but as far as competitive bidding, no. As I understand the question, no.

Senator ANDREWS. And you are not anticipating the closure of any hospitals in your area?

Ms. ROBERTSON. Not if I can help it.

Senator ANDREWS. What kind of response have you got from tribes or individual Indians as a result of elimination of treatment for non-Indian spouses?

Ms. ROBERTSON. We felt the impact was not small but it certainly was not great.

There have been some very heart-wrenching individual cases. I think the first day we got that edict we had an elderly lady who had been married to an Indian man and had lived on the reservation for 40 years. She was on medicare and medicaid and then we had to tell her she was no longer eligible to get her medications at the hospital. We have had those kind of individual cases at the reservation. I am not sure whether she got her medication herself. I did not look to see.

But those are really the heart-rendering things we see. However, the tribe has fully supported that and I agree with that. But there was little or no impact, I would say, in our area, at least to my knowledge.

Mr. BUCKANAGA. Senator, may I make a comment on it?

Senator ANDREWS. Surely.

Mr. BUCKANAGA. Competitive bidding—I should correct myself on the case I just cited. It did create a problem for us in the clinic that we were normally dealing with for 10 years. The clinic that got the contract, the delivery of service was not equal. We got a lesser service out of the new bidder and we had to go open market to provide services for the other contract, and it was more costly.

Senator ANDREWS. What do you do in managing a program in your area to avoid the horror story that was told earlier of the doctor and the cotton in the navel treatment?

Mr. BUCKANAGA. We do audits on the statements that we receive periodically and we do try to consult with them.

In some areas I would take the tasks to the congressional level by the vendors because of their letters to Congress or their Senators that: "I will not cooperate, I will not pay their bills," and that type of thing.

However, once we submit the facts to congressional people they always give us their support in allowing us to not continue contracting with certain vendors, whether they be physicians or pharmacists or even clinics or hospitals. However, it has not been that drastic yet.

Senator ANDREWS. Well, Ms. Robertson, what kind of screening process do you have in your area? I understand it is in your area that this cotton treatment took place. How do you prevent that?

Ms. ROBERTSON. Well we are screening very carefully now. We are working very closely with John McNaughton. In fact, we were using

the AMA Physicians Service to assist us with the interviewing, which we now are doing ourselves, interviewing those physicians.

Unfortunately in the past year we have had to terminate 10 physicians which is unfortunate because I was criticized because they keep sending me physicians and I keep getting rid of them. But at least those 10 were severely impaired physicians with no ability for practicing medicine while at least 2 or 3 were fairly valuable. I did not feel I had the wherewithal to deal with those folks, so consequently, we have terminated at least 10 or 11 physicians as of last week.

Senator ANDREWS. What you are telling me is that the group that sent this doctor in who was imposing cotton in the navel treatment on his patients was the AMA?

Ms. ROBERTSON. Well, they were screening only for licensure. They were not screening for other things. And they are doing better now. We were complaining about the type of physician that we were receiving because it cost us money.

Senator ANDREWS. Would you not expect something better from the AMA?

Ms. ROBERTSON. I would hope so.

Senator ANDREWS. Well, I guess out in the field is where you find the answer to some of these problems. You have been most helpful and I appreciate so much your coming and being candid.

[Submitted material follows:]

THE FOLLOWING MATERIAL WAS SUBMITTED BY MR. JOHN
BUCKANAGA, DIRECTOR, BEMIDJI INDIAN HEALTH SERVICE PROGRAM

BEMIDJI PROGRAM OFFICE

INTRODUCTION

The Bemidji three-state area tribes of Minnesota, Michigan and Wisconsin fell victim to negative federal legislation and policies over the past 50 years, whereby, federally funded projects and programs were terminated and facilities were closed in favor of unilaterally transferring the authority and responsibility to local and State governments. In most cases, this was unacceptable to both the State governments and also to the tribes. The States felt this was a Federal responsibility and a burden to the State. The tribes felt that the Federal government was removing their commitment of being responsible for Indian programs legally and morally. This attitude is still reflected by the States and also by the tribal governments. As an example, the tribes are adamantly opposed to the block grant processes because the States are generally insensitive to Indian affairs and that it causes another layer of bureaucracy for tribes to contend with in their attempts to secure funding for tribal and Indian development programs.

Termination policies were Federally mandated in the 1950's as the eastern tribes fell victim and the movement began westward. Tribes, however, resisted and stopped the westward movement. However, the Michigan, Minnesota and Wisconsin tribes were terminated silently as federal funds diminished and programs such as health care began to be adversely affected.

Since the early 1970's, with the advent of OEO programs, Tribes have now begun to restore services and programs with their limited resources, both human and financial. This is also true with health services.

BEMIDJI PROGRAM OFFICE

The Bemidji Program Office has been an operational entity of the Indian Health Service since 1955. The nine member staff assigned in those early years coordinated the provision of the contract and direct health services to approximately 20,000 Indian people living within the boundaries of IHS service units. The closure of four IHS hospitals during 1950-60's and the reduction of one facility from hospital to health center status meant that only three direct care facilities were available to provide the treaty mandated health care for these individuals.

In 1970, only \$2,250,000 was provided for all Indian Health Services in the states of Michigan, Minnesota and Wisconsin. (The 1970 census of service unit areas was approximately 11,000.) The rising expectations born during the social programs of the 1960's, the mandate of P.L. 86-121, and the recognition by various administrations and Congressional groups of the responsibility to meet the health care needs of this group of citizens leads to increased localization of program management effort. By 1975, tribal leaders in the three states had succeeded in convincing the Ford Administration of the need for greater autonomy from the Aberdeen Area to meet the escalating demands of the program in this Area. Additional subsequent Congressional and Administration mandates, principally P.L. 93-638, P.L. 94-437, and most recently, P.L. 97-394 have made the creation of the Bemidji Program Office appear to be a far-sighted administrative fiat. However, the Bemidji Program Office originally was grossly underfunded and understaffed in terms of the population served and voluminous workload identified by 1975.

Since 1975, program allowances have grown over 450% (from \$6,500,000 to \$30,000,000). Present three-state patient care IHS staff totals 248, while the Bemidji Program management staff is currently 42 FTEs. The Bemidji Program Area is currently managing nearly \$18.3 million in 100 contracts (principally 638 variety) with the 29 recognized tribes in

the Area. Technical assistance and program evaluations are also provided on 12 contracts for urban health services or alcoholism projects. The 1980 census counted 45,868 Indian residents of service unit areas in the three states, with a total population of 104,561. (An estimated 20,000 Michigan Ottawas are planning to seek Federal recognition which would increase the Indian population over 125,000 as well as increasing the reservation services.)

The responsibilities involved in providing quality technical assistance to a multiplicity of direct and contracted programs has been met, in my estimation, in an exemplary manner by the limited staff at my disposal. At least ten of the current (program management) employees are involved in varying degrees of patient care, providing an additional \$750,000 of care and direct services. Seven of these also fulfill project officer duties. Others hold dual responsibilities, such as Pharmacist/Program Planner, CHR/EMS Coordinator, etc. The average secretarial support per professional position in the office is approximately 25%. There are no mid-level technical positions such as statistical assistant, staff assistant, etc., to whom the professional staff may delegate responsibility. The record health plans, development and utilization of third party resources to supplement the Contract Health Care program, initiating cost-settlement rate contracts with private vendors, building the new Red Lake Hospital, the Menominee Health Center, Oneida Health Center (all under P.L. 93-638) and assisting Area tribes to develop their direct and contract health care system is one of excellence. The planning and future construction of the Cass Lake Hospital addition is another example of program development accomplishment. The White Earth Service Unit received the first Medicaid reimbursement check in the IHS when authority to collect these funds was granted in Title IV of P.L. 94-437. Red Lake, Cass Lake and Kincheloe IHS facilities also did this with no increase in staff and with only minimum of guidance and technical assistance from the Bemidji Program Office personnel.

Another outstanding recent accomplishment of our staff was their expertise and ability to negotiate and implement cost-settlement rates (using Medicare/Medicaid rates) with twelve (12) major hospitals and eight (8) major outpatient clinics which provide the greatest amount of health care to many of the Indian patients in the three-state Area. P.L. 93-638 tribal health management programs are also considering using the same procedures BPO-IHS has developed. It is projected that \$390,000 would be saved and further reprogrammed into the Bemidji Program Area Contract Health Care program.

Since the Bemidji Office became a separate entity from the Aberdeen Area Office, three (3) tribes were either federally restored or federally recognized by Congress, namely the Menominees of Wisconsin (1973), the Sault Ste. Marie Chippewa of Michigan (1975) and the Grand Traverse Band of Ottawa/Chippewa of Michigan (1981). All research and subsequent program planning and action to restore health care and services was developed and implemented under the direction of the Bemidji Program Office. This included program design, fiscal management and budgetary design, developing a staffing module, and construction of a major outpatient clinic facility. This is another striking example of the ability and expertise of the Bemidji Program Office.

In every instance, this office has met requests from higher authority programs in an orderly and timely manner. The Area has financially functioned in a prudent and austere manner to get the most of the limited program funds allocated to this Area. The headquarters' personnel has reported satisfactory to excellent dealings with the Bemidji Program staff on a number of projects over the past several years. Only the tribal leaders in this Area can, however, appreciate the impact this office has had on the improvement in health services delivered to their people. These changes would not have occurred if this office had not been responsive or if the office had been located in a more remote location and been charged with servicing an even larger number of tribes.

UNMET NEEDS

In order to provide maximum health care and delivery of health services to the Tribes of Minnesota, Michigan and Wisconsin, additional resources in the amount of 34.85% are needed for a total health care program. This deficiency includes all aspects of the Indian Health Service Program.

ADDRESSING THE PHYSICIAN SHORTAGE IN INDIAN HEALTH SERVICE

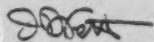
(Prepared for Field Hearing of United States Senate Select Committee on Indian Affairs at Grand Forks, ND, on 2 June 1983.)

The Bemidji Program Indian Health Service (IHS) faces an acute shortage of physicians within the next five years due to the phase-out of the National Health Service Corps (NHSC) scholarship program. 70% of Bemidji Program IHS physicians are scholarship obligees. No new NHSC scholarships have been granted since 1980. Current experience is that non-scholarship physicians are not applying in greater numbers: in fact, their numbers have declined over the past 3 years despite increased efforts to recruit them. We are thus projecting that unless corrective action is taken we face a 50% vacancy rate in our 22 physician positions by 1987-88. (This does not include current program needs for 4 additional physicians as well as associated support staff for which no funds or positions presently exist.)

Increasing numbers of students are receiving loans for their medical education through the Guaranteed Student Loan (GSL) and the Health Education Assistance Loan (HEAL) programs. It is projected that during 1987-88, as many as 10,000 medical students may use HEAL loans of \$10,000 to \$20,000 per year. Medical school graduates in 1988, and even before, could have debts of \$40,000 to \$80,000.*

A loan-forgiveness program has already been proposed within the agency and department. I wish to encourage Congressional support of this program which would grant loan forgiveness of an established amount for each year of service rendered by GSL and HEAL physicians to IHS. Consideration should also be given to varying the amount of loan-forgiveness with the site selected. As an example, our "hard-to-fill" or "less-requested" sites could result in \$20,000 loan-forgiveness for each year of service while other sites could result in \$10,000 loan-forgiveness for each year of service. Of course such a program would not need to be limited to IHS nor to physicians; but could extend to other shortage areas and health professions.

Because of the lead time required to establish such a program and the known phase-out of the NHSC scholarship program it is extremely urgent that action be taken soon: and that identified obligated manpower be available for the July, 1987, physician vacancies. Lacking some type of obligated program will result in a health-care crisis not only in the Bemidji Program IHS, but also in most of the IHS Areas/Programs.


J.D. Fett, M.D.
5-26-83

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1. Sandson, JE. "A Crisis in Medical Education: The High Cost of Student Financial Assistance". New England Journal of Medicine. 308:1286-9, 1983.

BEMIDJI PROGRAM AREA OFFICE
INDIAN HEALTH SERVICE

PREVENTIVE HEALTH SERVICE

Community Health Nursing - The future emphasis of the Indian Health Service as indicated in the recent ask force report is on preventive health services. The community health nursing program is the largest component of preventive health services. While most of the programs are below the RRM recommendations for staffing, there are two that are particularly underfunded. At White Earth, the funds available for direct care are approximately \$7.99 per capita and at Greater Leech Lake the figure per capita is \$6.35. The average per capita funding for the three largest programs (not including White Earth and Greater Leech Lake Reservations) is \$22.25. It is clear that in order to fulfill the requirements of a preventive program that will produce positive results, these programs are high on the priority list for additional funding to achieve staffing levels as established by RRM.

Hospital Health - The Cass Lake Hospital has a serious shortage of allocated nursing positions. To maintain a level of safe care, it has been necessary to transfer patients to contract services approximately twice a monthly. The patient classification system, which is based on methodology that is utilized nationally and recommended by the National League for Nursing, shows that to provide full safe care 13 professional nursing positions are required for the inpatient service alone. There are currently nine (9) allocated positions at Cass Lake to provide services to both inpatient and ambulatory care. In order to maintain consistently safe quality services at least two full-time permanent nursing positions are required at a cost of approximately \$48,000.

BEMIDJI PROGRAM AREA OFFICE
HOSPITAL & CLINICAL SERVICES

AUDIOLOGY SERVICES

(Prepared for Field Hearing of United States Senate Select Committee on Indian Affairs at Grand Forks, ND, on 2 June 1983.)

When comparing the funding and staffing levels for audiology services among the eleven Areas of the Indian Health Service, the Bemidji Program Area ranks ninth in per capita allocated funds and sixth in per capita allocated staff positions.

Per capita funding for audiology services in the Bemidji Program Area is \$4.32/capita using RRM FY-83 projected population (\$3.43/capita using 1980 census data). The all IHS average per capita expenditure for audiology services is \$6.07.

The RRM staffing criteria calls for the Bemidji Program Area to have 5.66 audiology positions, or one position for every 6,204 of service population. Bemidji currently has only two allocated positions (one position for every 17,557 of service population).

In order to bring the Bemidji audiology staff in line with the RRM projections and in order to meet only the IHS average per capita expenditure the following additional funding is needed;

Additional 3.66 positions at \$24,000/postion/year	\$ 87,840
Additional \$2.64/capita expenditure for 45,868 of population	<u>\$121,092</u>
TOTAL <u>additional</u> funding/year to meet FY83 requirements -	\$208,932

James D. Goins

James D. Goins
Chief, Communication Disorders Branch
Indian Health Service
Bemidji Program Office

ADDRESSING THE DENTAL PROGRAM REQUIREMENTS
IN IHS/BEMIDJI PROGRAM AREA

(Prepared for Field Hearing of U.S. Senate Select Committee of Indian Affairs
at Grand Forks, N.D., on June 2, 1983)

The Bemidji Program Area of the Indian Health Services faces several acute shortages in the areas of: staffing, resources and facilities.

Severity of the Problem:

Dental diseases probably constitute the most prevalent health problem in the nation. Tooth decay and periodontal diseases can be difficult and expensive to treat. Loss of teeth occurs if conditions are left untreated or if treatment is delayed. Fluoridation, especially of community water supplies, can prevent 65 percent of dental caries and 50 percent of children's dental costs. Fluoridation of community water supplies can save \$50 for every dollar invested.

Dental caries affects 98 percent of the nation's population. By 17 years of age, 94 percent of children have experienced decay in their permanent teeth, and nine permanent teeth are affected on the average. Children from low income families have nearly four times more untreated decayed teeth. Of all the children under the age of 12 years, 47 percent have never visited a dentist. Almost one-third of the children between 12 and 17 have gingivitis. Injuries to the mouth and teeth from play or sports is also significant.

TABLE I.

IHS DENTAL DATA SUMMARY 1982

NOTE: The following information is the actual productivity of IHS Dental Clinics including the Bemidji Program Area. This information is the same information used in the budget hearings.

CRITERIA	1982		1982	
	IHS NATIONAL DATA		BEMIDJI PROGRAM AREA	
<u>Cost Data Analysis/Direct Program</u>	IHS	Tribal	IHS Managed	Tribally Managed
Cost Per Patient	\$97.48	\$	\$ 78.63	\$ 92.79
Cost Per Service	\$15.21	\$ 2.62	\$ 13.39	\$ 13.60
Cost Per Service Minute	\$.99	\$ 0.12	\$.89	\$ 9.75
<u>Dentist Productivity IHS/Tribal</u>				
Patients Seen Per Position	786		804	586
Services Provided/Position	1,816		1,888	1,340
Percentage of Population Seen	29.2%		25%	

Source of Data: '84 Congressional Hearings Background Material.

IHS Water Fluoridation efforts have not resulted in continued optimal fluoridation in Indian communities.

The Indian Health Service (IHS) has actively promoted the fluoridation of community water systems serving American Indians and Alaska Natives since the late 1950's.

The failure to initiate or continue optimal fluoridation can be quite costly in the terms of suffering, disease prevention and resources required to correct the sequelae of dental decay. Figure I projects the anticipated per capita cost in FY 83 for providing optimal fluoridation to communities of various size. This cost ranges from a high of \$6.97 per capita for communities of 25 homes, to a low of \$1.17 per capita in a community of 500 homes. With an expected decay reduction of 60%, the overall cost implications are significant.

FIGURE I

WATER FLUORIDATION COSTS

<u>Number of Homes Served</u> <u>(4.5 Persons/Household)</u>	<u>Cost Per Year Per Capita</u>
25	\$6.97
50	3.79
100	2.21
200	1.39
500	1.17

Efforts in the Bemidji Program Area in the Area of Community Water Fluoridation:

72 community water systems (ranging in size from five to two hundred and fifty homes on the system), 27 community water systems with 25 homes or more, and 25 water systems with fluoridation equipment installed.

During the Fiscal Year 1982, only three systems operated at optimal levels for nine of twelve months.

It is recognized that education is an important compound in dental disease prevention to modify behavior patterns regarding diet, tooth brushing, and flossing. Recommended educational measures must include public education to promote fluoridation of community water supplies; and using mass media, school classes, and group presentations to promote dental health.

IHS Dental Program Resources and Staffing Patterns:

Comparison of IHS Direct Dental Resources for FY-83 by Area/Program.

TABLE II. IHS DENTAL RESOURCES - DIRECT CARE PROGRAM
(Using FY 83 Population, Positions,
and Recurring Funding Distribution)

<u>Area</u>	<u>Population</u>	<u>Positions</u>	<u>Recurring \$ Base</u>	<u>Cost Per Position</u>	<u>Cost Per Capita</u>
Aberdeen	59,601	61	\$ 1,555,000	\$25,492	\$26.00
Albuquerque	50,006	76	1,969,000	25,908	39.00
Alaska	76,626	71	2,377,000	33,479	31.00
Bemidji	45,682	20	608,000	30,400	13.31
Billings	41,171	56	1,335,000	23,839	32.43
California	49,778	0	-0-	-0-	-0-
Navajo	163,158	127	3,087,000	24,307	18.92
Oklahoma	153,966	132	3,331,000	25,234	21.63
Phoenix	81,324	60	1,608,000	26,800	19.77
Portland	63,624	39	1,104,000	28,307	17.35
Tucson	16,917	6	157,000	26,166	9.28
USET	25,238	14	444,000	31,714	17.59
TOTAL	827,091	674	\$18,196,000	(\$26,997 Average)	

Staffing Projections Based Upon Existing Positions and Dollars

<u>Area</u>	<u>Comparison of Positions to Dollars</u>	<u>Comparison of Positions to Population</u>
Aberdeen	57.6	48.9
Albuquerque	72.9	41.1
Alaska	88	62.9
Bemidji	22.5	37.5
Billings	49.5	33.8
California	----	----
Navajo	114	134
Oklahoma	123	126.5
Phoenix	59.6	66.8
Portland	40.1	52.3
Tucson	5.8	13.9
USET	16.5	20.7

Based upon the current resource distribution of positions and recurring direct dental dollars, the Bemidji Program Area cannot meet the oral health needs of IHS service population.

In view of the current per capita funding the Area ranks eleventh (11th) when compared to IHS-wide data.

This need for additional resources is intensified when we examine the dwindling dental contract care budget. Over the past three years, we have seen a sizable decrease in the Area's Dental Contract Care budget. Most programs have not seen an increase in Contract Care dollars during this period. Our Area Dental Contract budget has decreased from \$444,849 in FY-80 to \$313,326 in FY-82 (a net decrease of 30% in available care dollars). This decrease is compounded when we consider that dental care costs rose approximately 10-15% during this same period. When we consider the total number of services provided to Indian patients in the three-state Area, we have seen a net decrease in services of 24% (19,594 services provided in FY-80 compared with 14,537 services provided in FY-82 under the Contract Health Program). This decrease in services can be directly related to the loss in purchasing power of dental dollars and the decrease of available Contract Dental Care dollars.

In view of the current staffing pattern across the Indian Health Service, the Bemidji Program Area has the lowest dentist to dental auxiliary ratio, that being (1) dental officer to (1) dental auxiliary.

TABLE III. DENTAL STAFFING PATTERNS
(IHS Direct Care Program)

	Dental Officer	Dental Auxiliary	Ratio DO : DA
Aberdeen	22	31	1 : 1.4
Albuquerque	25	37	1 : 1.48
Alaska	34	38	1 : 1.12
Bemidji	10	10	1 : 1
Billings	15	36	1 : 2.4
Navajo	46	80	1 : 1.74
Oklahoma	42	81	1 : 1.93
Phoenix	21	39	1 : 1.86
Portland	17	21	1 : 1.24
Tucson	5	5	1 : 1
USET	5	9	1 : 1.8

The recommended staff ratio for IHS dental clinics is one dental officer : two dental auxiliaries (1:2 ratio). At the present time, the Area requires an additional twelve dental positions and funding for fourteen positions (this would support the two existing positions currently being held vacant since FY-81).

These additional positions would bring the existing staffing to the 1 DO : 2 DA staff ratio and increase the dental funded positions to thirty-four (34).

The expected additional program cost would amount to \$245,000 (14 x 17,500 = \$245,000).

1 DO : 1 DA Team \$67,500/year - 5000 services

1 DO : 2 DA Team \$85,000/year - 7500 services

This should increase the projected services provided by 35,000 services per year to an estimated 70,000 services as compared to the 37,761 (FY-82).

MENTAL HEALTH/ALCOHOLISM ISSUES FOR THE BEMIDJI PROGRAM OFFICE

Prepared for testimony before the Senate Select Committee on Indian Affairs held
June 2, 1983

Mental Health and Alcoholism issues among Native American populations have been well-documented over the years through various studies, Commissions and Congressional Committees. The findings of these various activities resulted in special attention and funding for Indian-based programs in both the Mental Health and Alcoholism fields. This funding continues to the present date. For the Bemidji Area, the concern lies in the level of funding and the program deficiencies that currently exist due to inadequate funding.

The IHS Model for tribal Community Mental Health Programs was based on a minimum of one local para-professional staff person and one professionally-trained Mental Health person, plus clerical support. This community-based team would carry out functions of education, prevention, intervention, case finding, problem assessment and treatment. For more complicated problem issues, consultants would be available to assist with diagnostic services and in development of adequate treatment plans. For tribes whose populations were below the minimum level of 1,600 persons, a proportion of the above model would be allocated, with the exception that the para-professional position would not be reduced to a part-time basis.

Of the 29 tribal entities in the Bemidji Program Area, 12 have in place minimum Mental Health components. Sixteen (16) are deficient. These are as follows:

<u>Tribes</u>	<u>Population</u>	<u>Present Staffing</u>
Nett Lake Chippewa	1,542	None
Grand Portage Chippewa	284	None
Mille Lacs Chippewa	1,010	None
Lower Sioux	211	None
Prairie Island Sioux	251	None
Upper Sioux	132	None
Shakopee-Mdewakanton Sioux	198	None
Bad River Chippewa	1,132	None
Stockbridge-Munsee	1,321	1/5 position
Sokaogon Chippewa	221	None
Bay Mills Chippewa	490	None
Keweenaw Bay Chippewa	1,137	None
Michigan Potawatomi	351	None
Sault Ste. Marie Chippewa	4,842	None
Grand Traverse Ottawa/Chippewa	1,081	None
Saginaw Chippewa	834	None

The funding needed to bring these programs up to a minimum level of Mental Health Resources is \$411,000. The deficit was arrived at by using three (3) positions or the model program consisting of one professional at \$30,000; one para-professional at \$15,000; and one clerk/secretary at \$10,000. The above tribal requirements were then arrived at by using their populations in proportion to the base of 1,600 persons.

The Bemidji Area Alcoholism Program consists of management of NIAAA programs that were in existence in 1978 and which were transferred to the Indian Health Service through Congressional action. These programs were transferred in varying states, depending on what was operating under NIAAA. As such, some programs are in relatively good shape program-wise and some are seriously deficient. Since the original transfer to the Indian Health Service and the Bemidji Program Office, we have received no new monies to address funding or program deficiencies, but have simply been able to only carry on as best we can. Alcoholism remains as one of the most serious health problems found among Native American populations and it has been given high priority by the Indian Health Service in its current ordering of health priorities. This priority will not be realized unless the funds are available to develop adequate programs for each tribal entity.

The deficiencies which we are identifying are listed below, and apply mostly to tribes who are managing/operating an outreach component. The model for comparison is our belief that each outreach component should have one full-time counselor, one full-time office assistant and support funds for travel, training, space, supplies, etc. The cost factors utilized are \$12,000 for the counselor position, \$8,000 for the office assistant and \$5,000 for the support budget. The tribes with deficiencies are as follows:

Tribe	Present Program	Funding
St. Croix Chippewa	3/5 counselor	\$13,583
Bad River Chippewa	1 counselor	17,716
Lac Courte Oreilles Chippewa	1 counselor	14,248
Lac du Flambeau Chippewa	1 counselor	14,471
Forest County Potawatomi	1 Counselor	19,327
Stockbridge-Munsee	1 counselor	19,300
Oneida	1 counselor	14,608
Red Cliff Chippewa	1 counselor	13,249
Michigan Potawatomi	4/5 counselor	13,668
Bay Mills Chippewa		13,676

In addition to the above, we have two (2) residential programs with funding shortages that have the current effect of reduced operation and poor utilization of staff. These programs are:

	Budget	Need
Wren Halfway House for Women	\$51,000	\$90,000
Ga-Wein-Min-Nee-Qwe Halfway House	46,220	76,000

The total funding for the Bemidji Area Alcoholism Programs necessary to bring them up to minimum operating level is \$175,000.

BEMIDJI AREA PROGRAM - CHS

PREPARED FOR FIELD HEARING OF UNITED STATES SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
AT GRAND FORKS, N.D., ON JUNE 2, 1983.

I. Overview of CHS Program

The appropriated dollars for the Contract Health Service Program has been falling far behind medical inflation. For example, in 1983 hospitalization charges rose 20.6% and physician charges rose 7.7% in Minnesota while our CHS budget was increased only by 5.5% in FY'83. In order to absorb this medical inflation it was necessary to operate our CHS program on priority I medical care during FY'82 and the first half of FY'83.

The Bemidji Program Office would require an additional one million dollars in order for our Area to meet all CHS unmet medical needs. In addition our contract health service administrative staff is 56% under-funded which hampers our ability to provide quality assurance and the necessary audits for contract rate billings and charges.

II. Projected Effects In Your Service Area If Recommendations Made By The IHS Task Force On Contract Health Care Services To The Director Of Indian Health Service Were To Be Implemented.

Response:

There are 24 recommendations and 23 of them are excellent. Most of the recommendations would enhance the management and operation of the CHS Program. For example the development of a basic benefit package with medical priorities would provide an assurance of medical care to Indian patients. Other recommendations would make it possible for billing third parties with IHS retaining the receipts for unmet needs. A very important recommendation which requires congressional legislation would allow IHS authority to bill using medicare methodology. In order to effectively enhance our overall CHS operation we must according to the recommendations improve our computer capabilities.

The only negative recommendation is the one pertaining to eligibility for IHS Services. This one terminates all Indians for IHS services unless they reside in a contract health service delivery area. It also requires enrollment with a Federally recognized Tribe which indirectly means an Indian person must be 1/4 degree blood quantum as most Tribes in our area require this amount for enrollment.

III. The Impact Of Competitive Bidding On The Quality Of And Access To Health Care In Our Service Area.

Response:

The Bemidji Program Office followed the procedures for competitive bidding in contracting with medical vendors in FY'83. We were highly successful as all 19 of our hospitals offered us their State Medicaid Rate or a Cost Settlement Rate less than their usual and customary charges. Likewise, 6 of our major contract clinics offered a cost settlement discount of from 5% to 15% discount. We have been able to expand our priorities somewhat with the dollars realized from these cost settlement rates.

BEMIDJI PROGRAM AREA OFFICE

P.L. 93-638 Contracting

Actual and potential problems related to the P.L. 93-638 Contracting process identified within the Bemidji Program Area include:

1. There is a need to provide for comparable cost of living/pay act increases on tribal contracts within the Bemidji Program. There are 500+ tribal health employees under P.L. 93-638 contracts with an annual estimated pay-roll of \$10,000,000. It is projected that a recurring increase of \$500,000 (based on a 5% average Pay Act increase) would be required annually to maintain salary level equivalency and program integrity on existing contracts.
2. Further expansion of the P.L. 93-638 contracting process will be hindered unless additional resources are made available to support Direct and Indirect Administrative Costs on Tribal Health contracts.

Estimated Administrative Cost unmet need for FY '84 P.L. 93-638 contracts is \$950,000 based on an average Administrative Cost of 15% on \$15,000,000 of Tribal Health Contracts.

Total Need	\$ 2,250,000
Currently Available	<u>1,300,000</u>
Unmet Need	\$ 950,000

INADEQUACIES IN HEALTH EQUIPMENT & FACILITIES

(Prepared for Field Hearing of United States Senate Select Committee on Indian Affairs at Grand Forks, ND, on June 2, 1983.)

Indian Health Service owned health facilities at Ponemah, Red Lake Reservation, MN & Naytahwaush, White Earth Reservation, MN are deteriorated in addition to being functionally inadequate and do not meet the Joint Commission on Accreditation of Hospital Standards, Life Safety Code or GSA Handicapped Accessibility Standards. The Bemidji Program Office will be requesting the use of \$500,000 in Medicare/Medicaid funds to construct and equip a temporary addition to each of these existing facilities.

We are concerned that the need for such additions is of a critical nature, yet the limitations on new construction imposed by the Congressional Subcommittees on Interior & Related Agencies are such that the approval process may take up to two (2) years, meaning actual occupancy of a new facility may be 4-5 years after a need is identified.

Small, Tribally operated health clinics in the Bemidji Area have a need for new facilities or additional space since expanded services and increased demand for services have caused many of these clinics to be functionally inadequate. In most cases, Tribal resources are inadequate to support new or expanded facilities and there is presently no mechanism for Indian Health Service to financially assist or support these needed facilities.

It is estimated that \$5-6 million would be necessary to upgrade facilities at Lac Courte Oreilles, St. Croix, Lac Du Flambeau & Wisconsin-Winnebago, Wisconsin; Grand Traverse, Michigan; and Bois Forte & Fond du Lac, Minnesota. Possibly, a portion of Medicare/Medicaid funds could be used to support these improvements.

SENATE TESTIMONY - JUNE 2, 1983
OFFICE OF ENVIRONMENTAL HEALTH
BEMIDJI PROGRAM OFFICE

The unmet needs for water and sewer facilities as submitted in February 1983 indicated a total of \$1,167,300.00 for Michigan; \$ 2,590,700 for Minnesota, and \$2,932,500.00 for Wisconsin. This results in a total expected cost of \$6,690,500.00 for unmet needs for installation of water and sewer facilities.

A shortage of personnel in the Office of Environmental Health, Bemidji Program Area is documented by a Workload Staffing Analysis completed by the OEH Headquarters Office. This analysis indicates that the Office of Environmental Health should have a total of 36 staff members - it is currently staffed with 17 staff members leaving a deficit of 19. The staff is currently divided with a total of 11 in the Sanitation Facilities Construction Branch (engineers) with a need of 24.4 = 13.4 deficit. Environmental Health Services Branch (sanitarians) currently is staffed at 6 with a need of 11.6 = 5.6. Total personnel staffing costs are \$456,000.00.

A major emphasis area for the Office of Environmental Health is Community Injury Control. Additional funds for equipment, supplies and training of staff as well as reservation residents are needed. It is estimated that an additional amount of \$50,000.00 is required for Community Injury Control.

The Bemidji OEH has encountered a problem as a result of 638 contracting of Sanitarian positions. Due to few sanitarian positions available the IHS staff cover 2 or 3 reservations and are located in an area advantageous to reaching these reservations. When the position is 638 contracted to one (1) reservation the remaining reservations must be covered by current IHS staff. This results in an unusually high workload for current IHS staff members.

The Office of Environmental Health provides training and technical assistance to tribal system operators and the various tribes, but because of high unemployment and cut backs on federal programs at the Reservation level, funds for system maintenance is difficult to generate from user fees. To extend the useful life of sanitary facilities installed, operator training, system inspections and technical assistance must be provided by the Indian Health Service on a more frequent basis than we are now providing because of staff shortages.

P.L. 86-121 construction in the Bemidji Program Area is effected by cold weather conditions by limiting the construction season to about 6 months, facilities must be designed to operate under extreme cold weather conditions, and when the construction season arrives we are short of staff to manage accelerated construction activities.

GREAT LAKES INTER-TRIBAL ASSEMBLY

RESOLUTION GL 5-25-83-2

INDIAN HEALTH CARE LEGISLATION

WHEREAS, it is important that the House Committee on Interior and Insular Affairs prepare a bill to reauthorize the Indian Health Care Improvement Act during this session of Congress in order to have deliberations on the FY 1985 budget; and

WHEREAS, in the Indian Health Care Improvement Act Congress established a national goal of raising the health status of Indian people to the highest possible level while encouraging the maximum participation of Indians in the planning and management of their health services; and

WHEREAS, the Act represents and embodies the federal government's responsibility in providing health care to Indian people:

NOW, THEREFORE, BE IT RESOLVED, that the Great Lakes Inter-Tribal Assembly endorses the reauthorization of the Indian Health Care Improvement Act, P.L. 94-437, and the appropriation of funds sufficient to implement the high purposes of the Act.

C E R T I F I C A T I O N

I, Joseph K. Lumsden, Presiding Officer, do hereby certify that the foregoing resolution was duly presented and passed at the Great Lakes Inter-Tribal Assembly, representing twenty-nine (29) Indian Tribes located in the States of Wisconsin, Michigan, Minnesota and Iowa, held on May 23 and 24, 1983, at Sault Ste. Marie, Michigan.

Joseph K. Lumsden
Assembly Presiding Officer

GREAT LAKES INTER-TRIBAL ASSEMBLY

RESOLUTION GL 5-25-83-1

INDIRECT COSTS

WHEREAS, the Indian Tribes have endorsed the Indirect Costs system as a means to finance tribal administration expenses due to implementation of P.L. 93-638, the Indian Self-Determination Act,

WHEREAS, the said Tribes have cooperated with the Inspector General's directives in order to provide information to obtain the rate of the Indirect Costs, and

WHEREAS, the said Tribes have contracted a great number of Federal Agency programs in furtherance of the P.L. 93-638 provisions, but the appropriations are insufficient in FY 83 to meet the full level of overhead needs as perscribed by the Inspector General's Office, and

WHEREAS, the FY 83 appropriations cover only about 75% of needs, causing a large shortfall which creates an undue hardship on the said Tribes, even though substantial performance on the contracts has been made to date, and

WHEREAS, the under-recovery process compounds tribal cash flow maintenance and accounting burdens,

NOW, THEREFORE, BE IT RESOLVED, (1) that there be a supplemental appropriation in such sums as may be necessary to reimburse the Tribes for their shortfalls and (2) that the Appropriations Committee overhaul the procedures in order to eliminate the said shortfall and under-recovery process and fulfill the legislative intent of the contracting and Indirect Costs processes.

C E R T I F I C A T I O N

I, Joseph K. Lumsden, Presiding Officer, do hereby certify that the foregoing resolution was duly presented and passed at the Great Lakes Inter-Tribal Assembly, representing twenty-nine (29) Indian Tribes located in the States of Wisconsin, Michigan, Minnesota and Iowa, held on May 23 and 24, 1983, at Sault Ste. Marie, Michigan.

Joseph K. Lumsden
Assembly Presiding Officer

June 1, 1983

OPTOMETRYPROGRAM:

It has been the goal of the optometry program not just to conserve funding and to enhance the quality of primary eye care, but to expand the program to reach the presently neglected at-risk population.

It has been documented that at least 27.5% of the children of this Area begin their school years with significant eye problems; almost five times the non-Indian incidence. With each year of life, the incidence of eye problems becomes greater; to over 50% at high school age and to almost 100% by age 50. Diabetes presents a critical risk to many of the Indian people. These people need energetic educational efforts and expanded care to help prevent the tragedy of blindness.

Yet in this atmosphere of vital need and essential growth of primary eye care services, program regression is taking place. Critical primary care is being pre-empted by emergency-only levels of care. Only two tribes in the Area are at the predicted level of services (31% of the population). The median level is only 12%, and some tribes range as low as 3%. Progress has been halted at most locations, with only 6 tribes showing gains and 23 tribes showing declines, sometimes marked declines, over the past year.

The present low funding priority for the optometry program, and, just as damaging, the sporadic availability of funding (due to the continuing resolution routine) are seriously affected the growth of essential primary eye care to an acceptable level. It is difficult to educate and to advocate primary and preventive care when the care is not available.

FACILITIES:

At White Earth it becomes more critical each year that clinic space be expanded. The current mobile unit is inadequate for permanent clinic use and is reaching it's realistic life expectancy. Permanent space is needed.

CHS TASK FORCE RECOMMENDATIONS:

I would strongly endorse the attempts of the task force to achieve a greater level of equity in the level of services available to the Indian people of all areas. There is no other reasonable approach to health care delivery with limited resources.



Alan Schmierer, O.D.
Area Optometrist

Senator ANDREWS. We do appreciate everyone coming here and all of you in the audience, thank you for coming.

The hearing is adjourned.

[Whereupon, the hearing was adjourned at 2:30 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

CHAIRMAN
Morgan Garreau
SECRETARY
Arlene Thompson
TREASURER
Harold Condon
VICE-CHAIRMAN
Bernard Provost



Box 590
Eagle Butte, South Dakota 57625

July 15th, 1983

TRIBAL COUNCIL MEMBERS
DISTRICT 1
Percy Marrowbone
Raymond Ussie The Knife, Sr.
DISTRICT 2
Eagle Hunter
DISTRICT 3
Jerome White Horse, Sr.
Ivan Bruguler
DISTRICT 4
Carl Makes Him First
Justin Lawrence
Keith Jewell
DISTRICT 5
Gilbert Marshall
Jack Claymore, Sr.
Louis Vao
Bernard Provost
Lenny LePlant
DISTRICT 6
Germene Means
Robert Smith, Jr.

M's Patricia Zell
Staff Attorney
Senate Select Committee on Indian Affairs
Washington, D.C. 20510

Dear M's Zell:

This letter is to confirm my telephone conversation with a member of your staff of 07-05-83

Attached are documents that I am submitting for your attention, it is hoped that after reading the material, that you submit or have it incorporated into the Senate Select Committee on Indian Affairs as testimonial in support of Reauthorization of the Indian Health Care Improvement Act and other purposes.

I am sorry I have not included any other material as indicated in the appendices, but are standard forms, etc bearing on subject matters quoted in the text.

If you should have any questions regarding the material submitted, please do not hesitate to contact the undersign.

Sincerely:

Morgan Garreau,
Chairman of the Board
Cheyenne River Community College
and
Tribal Contracting Director
Cheyenne River Sioux Tribe
Eagle Butte, S.D. 57625

The blue represents the thunder clouds above the earth where live the thunderbirds who control the four winds. The rainbow is for the Cheyenne River Sioux People who are keepers of the Most Sacred Cal Pipe, a gift from the White Buffalo Calf Maiden. The eagle feathers at the edges of the rim of the world represent the spotted eagle who is the protector of all Lakota. The two pipes fused together are for unity. One pipe is for the Lakota, the other for all the other Indian nations. The yellow hoops represent the Sacred Hoop, which shall not be broken. The Sacred Cal Pipe Bundle in red represents Wakana Tanka - the Great Mystery. All the colors of the Lakota are visible. The red, yellow, black and white represent the four major races. The blue is for heaven, and the green for Mother Earth.

LEGAL ASPECTS OF INDIAN HEALTH PROGRAMS

Prepared by: and submitted to Dr. George I. Lythcott; Administrator, PHS, Health Services
Administration, Parklawn Bldg, 5600
Fishers Lane, Rockville, MD 20857
March, 1979

Mr. Manson A. Garreau

Tribal Contracting Director

Cheyenne River Sioux Indian Tribe

Eagle Butte, South Dakota 57625

(605) 964-8347

"The white man cannot pretend to be the doctor; he is the sickness" *

I. INTRODUCTION

The gravity of the Indian health problem cannot be overstated. The Public Health Service estimates the overall health status of Indians to be similar to that found in the general population thirty years ago, and this despite considerable improvement in the grim statistics since 1955 when P.H.S. assumed jurisdiction¹ from the B.I.A. over Indian health problems.

The extent and quality of health services available to the Indian people have a considerable bearing on their social and economic advancement. Health problems are closely related to a variety of other interdependent factors such as poor diet, inadequate housing, unemployment and psychological disorders. A number of government agencies, federal, state and local, have programs bearing directly on Indian health. These agencies are often prone to discharge their obligations in haphazard arbitrary and slipshod ways. Legal pressure may be effective in many areas to improve and expand the level

* Hobart Keith, Chief Judge, Oglala Sioux Tribe (1969)
1. U.S. Public Health Service, Indian Health Highlights, 1969.

of health and health-related services available to Indians, as well as in obtaining redress for individual Indians wronged by agency abuse or malpractice.

The following discussion will examine government programs bearing on Indian health, areas where abuse is most likely to occur, and possible avenues of recourse open to the attorney seeking health services for his Indian client.

II. FEDERAL HEALTH SERVICES

A. Background:

Army medical personnel were treating Indians as early as 1802, under the theory that Indians with contagious diseases living in the vicinity of army outposts might infect soldiers. The Indian Bureau continued these services under treaty terms and special appropriations after 1848.² No statutory authorization for health care existed until 1921 with the passage of the Synder Act, 25 U.S.C. §13:

"The Bureau of Indian Affairs, under the supervision of the Secretary of Interior, shall direct, supervise, and expend such monies as Congress may from time to time appropriate, for the benefit, care and assistance of the Indians throughout the United States for the following purposes:

General support and civilization, including education.

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2. U.S. Public Health Service, Indian Health Service, The Indian Health Program from 1800-1955, 1959.

For relief of distress and conservation
of health

...for the development of water supplies

...for the employment of...physicians..."

A number of hospitals and clinics were constructed by the Bureau at the larger agencies, and staffed by doctors hired by the B.I.A. or on loan from the Public Health Service. A separate Indian Health Division was established within the Bureau in 1924.

The record of the Bureau in operating these facilities was predictably poor, and was a source of considerable embarrassment in Congress and elsewhere. Public outcry at the abysmal health conditions on reservations and at the failure of the Bureau to deal with the problem induced Congress to transfer responsibility for Indian health to the Public Health Service in 1954.³

"All functions, responsibilities, authorities and duties of the Department of the Interior, the bureau of Indian Affairs, Secretary of the Interior, and the Commissioner of Indian Affairs relating to the maintenance and operation of hospital and health facilities for Indians, and the conservation of the health of Indians, are transferred to, and shall be administered by, the Surgeon General of the United States Public Health Service, under the supervision and direction of the Secretary of Health, Education and Welfare: Provided, That hospitals now in operation for a specific tribe or tribes of

3. 42 U.S.C. §§2001, et seq.

Indians shall not be closed prior to July 1, 1956, without the consent of the governing body of the tribe or its organized council. Aug. 5, 1954, c. 658, § 1, 68 Stat. 674.

In 1959, P.H.S. also was granted authority to provide water and sanitation facilities for Indian homes and communities.⁴

Since the transfer to P.H.S. Indian health appropriations have more than quadrupled, from \$24 million in 1954 to \$105 million in 1969. The number of physicians has increased from 125 in 1955 to over 400 in 1969, or about one for every one thousand Indians.⁵ Since 1954, there has been considerable improvement in the morbidity and mortality rates of diseases such as tuberculosis, pneumonia, and intestinal disorders. Infant mortality has declined by nearly half, since a high percentage of Indians are now born in hospitals.⁶

Despite this improvement, the health level of the Indian is the lowest of any major population group in the United States.⁷ For every one thousand live

4. 42 U.S.C. §2004 a.

5. U.S. Public Health Service, Indian Health Service, Indian Health Highlights, 1969.

6. Ibid. Statistical improvements in Indian health since 1954 may however be due as much or more to overall increase in reservation living standards, nutrition, housing and sanitation than to improved health services.

7. U.S. Public Health Service, Indian Health Service Justification for Appropriations, 1970. The following statistical data is taken from this source.

births on reservations, 35.9 infants die before their first year as compared to 24.8 for the population as a whole. On some reservations the rate is estimated as high as 100 per thousand, or⁸ twice as high as some of the worst urban ghettos. Life expectancy of a reservation Indian is still only 43.8 years (35 years for Alaska Natives), compared to an average of 63.6 years for the general population. Mortality from influenza is nearly twice the national rate; from tuberculosis, seven times as high; from dysentery, seventeen times as high. Esoteric nutritional diseases such as Marasmus (calorie starvation causing gradual wasting of body tissues) Kwashiorkor (extreme protein deficiency usually found only in Africa and Asia) are common on many reservations but virtually unknown elsewhere in the country. General malnutrition scars the physical and psychological development of more than a third of all Indian children.

In addition to physical sicknesses, and disease, psycho-social illnesses are widespread among the Indian population. The death rate from accidents, homicides and suicide is four times the national rate; from cirrhosis

8. Hearings Before the Special Subcommittee on Indian Education of the Senate Committee on Labor and Public Welfare, 90th Cong., 1st and 2nd Sess. at 1006 (1968). (Hereinafter cited as Education Hearings).

of the liver, five times the national rate. It is estimated that nearly 20 percent of all reservation Indians are in need of psychiatric help.⁹

The stated goal of the Public Health Service Indian Health Program has been to raise the health of the Indian people to "the highest possible level".¹⁰ Priority is given to hospitalization and treatment of the sick, as opposed to preventive medicine and health education. The effect of this policy is seen in infant mortality rates, which are lower than the general population for the first ten days of life, then increase dramatically after the mother and child are released from the hospital.¹¹

P.H.S. currently operates 51 hospitals on Indian reservations and 70 health centers (25 of which are located at B.I.A. boarding schools) through eight Area Offices and a Central Office in Washington. (See Appendix I). In addition, services are also provided through contracts between the Public Health Service and local hospitals, clinics, doctors and dentists under the Contract Medical Care program. An example of such a contract is attached as Appendix II. The P.H.S.

9. Id. at 2228.

10. U.S. Public Health Service Indian Health Service, Indian Health Manual, 1-3.4 (hereinafter cited as Manual).

11. I.H.S. Justification for Appropriations, 1970, at 3.

Indian Health program is administered by the Indian Health Service (I.H.S.) which is part of the Health Services and Mental Health Administration within P.H.S. It is ultimately under the direction of the Surgeon General and the Secretary of Health, Education and Welfare.

At each Area Office, the Area Director is responsible for planning and supervising the various services provided by the local Service Units within his area. He is the "commanding officer" for P.H.S. doctors in the area, and may transfer them or deny promotion almost at will. Most non-professional employees, unlike the doctors, have Civil Service status, and can claim the protections afforded in the Civil Service regulations. The Area Director also has the duty of negotiating for health services from private vendors under the Contract Medical Care program (CMC).

B. Operations:

The goal of the Indian Health Service to elevate the health of the Indians to the highest possible level¹² is to be accomplished through:

- (1) Institution of health programs which assure achievement of the Service goal through

12. Manual 1-3.4 b.

self-help activities conducted by and with the Indians and Alaska Natives to the ultimate realization of assumption of fuller responsibilities in meeting their health needs.

(2) Management of Service resources (manpower, money and materials), in a manner that provides a co-ordinated and balanced preventive curative and rehabilitative health program through a constantly updated Area-wide operations plan, initiated at the service unit level and consolidated in a comprehensive Service plan with Indian consultation and co-operation. (Emphasis added).

When funds, facilities, or personnel are insufficient to provide the needed volume of services, priorities for care and treatment, as among individuals, who are eligible, must be determined on the basis of "relative medical need and access to other arrangements for obtaining the necessary care."¹³ These priorities should be contained in the Area Operations Plan which may be obtained from the Area Director's office or from the central office in Washington.

The Indian Health Manual, which contains the rules and regulations for the P.H.S. Indian Health Service,¹⁴ states:

All services available at any I.H.S. facility will be provided as needed to any person within the scope of the program who presents himself at that facility and for whom the I.H.S. facility is more accessible than other programs and resources. Services needed but not

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13. 42 C.F.R. 36.12c See Appendix III for I.H.S. regulations relating to eligibility and scope of services.
 14. Manual 2-1.5B. Copies of the Manual may be obtained without charge from the central office.

available at the I.H.S. facility will be provided through the Contract Medical Care program depending upon:

1. The person's medical need, determined by a physician wherever possible.
2. The actual availability and accessibility of alternate resources.
3. The financial resources available to the I.H.S. facility at that time.
4. His personal resources.

Service units are only authorized to deny treatments where the patient is found to be not "within the scope" of the program.¹⁵

Treatments which are ordinarily available at the service unit cannot be denied simply because the Indian may also be eligible for services from other agencies or programs such as Medicaid or VA benefits, so long as the Indian feels the I.H.S. services are "more accessible" to him.¹⁶ His decision may be based on financial or family considerations as well as distance.

Services not available at I.H.S. facilities should be provided by I.H.S. through contracts with public and private hospitals, clinics, physicians, dentists and others under the Contract Medical Care program. In practice there are wide variations in the nature and extent

15. Manual 2-1.5C (1) (See Appendix III, p.4)

16. Ibid.

of CMC services available. CMC funds must be allocated according to the following priorities by the Area

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Directors:

1. Providing emergency services where these cannot be provided at an I.H.S. facility.
2. Providing non-emergency essential medical services in service units where I.H.S. facilities are not available.
3. Providing essential supportive medical services not available in I.H.S. facilities.
4. Providing non-essential and specialized medical services to meet specific needs of Indians to raise their health status to that of the nation as a whole.

The decision to authorize CMC services is made by the service unit staff after considering the four factors listed at note 14 above. An individual is required to obtain such authorization before he receives services. In emergency situations, hospitals are usually allowed by the terms of the CMC contract to provide services for up to 72 hours to an Indian who has not obtained advanced authorization. "Open market" purchases of medical services up to \$2,500.00 may also be made by I.H.S. service units in emergency situations. Thus, in such situations where I.H.S. facilities are not readily available, an eligible Indian should be able

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17. Manual 2-3.7
 18. Manual Exhibit 2-3.11(2)
 19. Manual 2-3.10F

to seek treatment from the most accessible hospital and have his expenses covered by I.H.S., since care for emergency patients is given the highest priority in allocating CMC funds.

Any denial or delay of services, or assignment of priority for CMC services, may be appealed to the Area Director.²⁰ The regulations contain no provision authorizing appeals to higher officials, although the Director of the Indian Health Service and his superiors have authority to overrule the Area Director's determination.

Fees

In some instances, service unit personnel may request payment for the cost of services to be rendered to the eligible Indian. This is most likely where the Indian has some income or resources and is seeking to utilize CMC services.²¹ The practice of charging fees to those able to pay was instituted in 1940 by the B.I.A. under a provision in the Indian Appropriation Act of 1939 authorizing the collection of fees in the discretion of the Secretary of Interior.²² Similar provisions were included in subsequent appropriations acts through

20. Manual 2-1.5C

21. 42 C.F.R. §36.13. See Appendix III, p.9.

22. 52 Stat. 291, 312.

1946, although not since that date, and thus there is no specific statutory authority for charging and collecting fees, or for conditioning services on the payment of fees. The General Counsel of the Department of Health, Education and Welfare has cited 5 U.S.C. 140 expressing the sense of Congress that Federal services performed for any person "shall be self-sustaining to the fullest extent possible", as²³ authorizing a request for payment. However, such a request gives rise to no legal obligation to pay, and services may not be withheld for refusal to pay. There likewise appears to be no statutory authority for considering an Indian's personal resources in the²⁴ assignment of priorities for CMC services. The basic responsibility of I.H.S. extends to the health of all Indians, regardless of their economic status.

Water and Sanitation

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Under P.L. 86-121, passed in 1959, the Indian Health Service is authorized to develop and implement safe water and water disposal facility construction programs. Over \$60 million has been provided in federal funds under this act along with almost \$30 million in labor, materials and funds contributed by Indians. In

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23. Memorandum to Deputy Chief, I.H.S. 2/16/60
 24. Manual 2-1.4C
 25. 42 U.S.C. 2004a.

addition to community water and sewage systems, wells, pumps, privies, and septic tanks are provided in rural areas. On many reservations, there has been substantial Indian participation in project planning, construction and maintenance.

P.L. 121 funds are allocated to the various I.N.S. service units on the basis of need and local willingness among the Indians to participate in the various phases of the program.²⁶ Need is measured by the adequacy of existing facilities and the incidence of enteric diseases such as dysentery, hepatitis, impetigo diarrhea and colitis, which are often linked to poor water and sanitation facilities.

The facilities provided under P.L. 121 vary widely in quality. In rural areas, most often a family will be allowed a well, gasoline pump, one indoor faucet and an outside privy. In villages, several indoor sources and a flush toilet may be provided. The decisions on who gets what facilities are made at the service unit level, sometimes after consultation with the Indians themselves.

26. Manual 3-11.3

The installation of P.L. 121 facilities has been found to have significant beneficial impact on the health status of the population served. The same research has shown, however, that little or no improvement results from the installation of one indoor source and outside privy, and funds expended for this type of facility are, from a health standpoint, wasted.²⁷ Often the water systems provided under P.L. 121 fail to conform to minimum standards of purity and quantity set by the Public Health Service itself. In addition, Indians are seldom trained to provide the necessary maintenance.

²⁸ According to P.H.S. standards, a water supply should supply at least a minimum of 50 gallons per day for each member of the household served. If the family has, or hopes to have, a vegetable garden, or appliances such as washing machines, they will require at least 100 gallons per day. P.H.S. has also developed standards for construction of individual and community wells and water purity.²⁹ P.L. 121 facilities often fall short of these standards, and may cause a serious health hazard.

27. I.H.S. Health Programs Systems Center: Impact Study of the Indian Sanitation Facilities Construction Act (1967).

28. P.H.S., Manual of Individual Water Supply Systems (1962).

29. Ibid.

Litigation is pending against Indian Health Service officials at several reservations in California as a result of slipshod construction of P.L. 121³⁰ water systems. These suits are based on three theories; first, that installation of an "inadequate" water supply system is a violation of 25 U.S.C. §2004a; second, that since the systems are usually installed pursuant to a contract, the installation of an inadequate system is a breach of that contract giving rise to a cause of action under 28 U.S.C. §1346 (a); and third, that the breach of contract is a violation of §2004a. In one suit, the court has granted the Indians a preliminary injunction requiring I.H.S. to truck in an adequate supply of water to the reservation while the action is³¹ pending.

Once the P.L. 121 facility is completed the I.H.S. provides little or no maintenance service itself, yet Indians are rarely instructed even in the basics of maintenance or repairs of their systems. Under 42 U.S.C. §2004a, the obligation of the I.H.S. to provide water

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30. Whiterock, et al. v. Udall, et al., Civ. No. 50584 (N.D. Cal., prelim. inj. granted Apr. 7, 1969) (See Appendix IV); Dry Creek Rancheria, et al. v. Hickel, et al., Civ. No. 51848 (N.D. Cal. filed July 30, 1969); Ames, et al. v. Hickel, et al., Civ. No. 52102 (N.D. Cal., filed Aug. 24, 1969).
31. Whiterock, supra.

and sanitation facilities does not cease once these are constructed and turned over to the Indians. There is a continuing duty to provide maintenance services, or at least provide instruction and training to the Indians so that the facilities can continue in operation.

Ambulance Services

An almost universal problem with I.H.S. facilities is their inaccessibility to broad segments of the Indian population. Many Area Directors and service units seem to feel their obligation to provide services runs only to those Indians who are able to "present themselves" at the local facility.³² Suggestions that the service unit provide some form of ambulance or bus service are often rejected on the grounds that the B.I.A. or the tribe is responsible for roads and transportation on the reservation. This view is inconsistent with the statutory mandate to provide services to all eligible Indians in need of them, as well as the I.H.S. policy of giving the highest priority to emergency services. Nothing in the law, regulations or Manual precludes the service unit from operating a transportation service to bring sick Indians to the facility

32. Manual 2-1.3A

or take doctors or nurses to the home. At Papago and several other reservations, ambulance service has been provided for some time by I.H.S. Telephones and two-way radios have also been supplied by I.H.S. at Papago to Community Health Aides living in rural areas so the ambulances can be summoned quickly in emergencies.

Nutrition

I.H.S. has made little effort to obtain adequate food or balanced diets for Indians, although diet is perhaps the most important single factor affecting Indian health. I.H.S. sees its responsibility as limited to counselling and education "not in food distribution".³³ I.H.S. has given technical assistance to an ONEO (Navajo) program to provide diet supplements for infants and their mothers. This program has substantially reduced the infant mortality rate among participants, and could be implemented by I.H.S. at other reservations with a tremendous saving of human lives. I.H.S. is also participating in the USDA Supplemental

33. I.H.S., Nutrition Problems Among American Indians and Alaska Natives (June, 1968).

Food Program for High-Risk Health Groups at Fort Yuma and Gila River reservations. Under this program, I.H.S. locates and certifies individuals as being in urgent need of food, and these are then eligible to receive free food provided by USDA and distributed by welfare agencies or tribes.³⁴ Again, this program could be implemented on other reservations, but I.H.S. has not yet seen fit to take the initiative.

Other Deficiencies

Other areas which have been generally neglected in setting priorities for care include convalescent and old-age facilities, hearing aids, and eye glasses even for school children, and dental care. In the area of community health education, I.H.S. employed only 17 public health educators in 1968. The lack of knowledge among Indians here is a major factor in both the high incidence of communicable and intestinal diseases and in the reluctance to obtain treatment for such diseases until they become acutely serious.

The high rate of suicides, accidents, alcoholism, child neglect, unemployment and family disorganization on the reservations attests to the urgency of the need for mental health services, yet since 1955 less than

34. See Appendix V, Guidelines for Service Unit Participation in USDA Supplemental Food Program (June 30, 1969).

\$600,000 has been spent by I.H.S. in this area.³⁵ In 1970 only \$156,000 was requested for mental health services in a total I.H.S. budget request of \$120 million.

On most reservations, dental care is non-existent or available only to young children. Some I.H.S. dentists reportedly never do more than pull teeth. The hardship and poor diet caused by bad teeth is the greatest single health problem for many Indians. By its own estimate, I.H.S. provides less than 20 percent of the treatments necessary for a minimal level of dental health among the Indians.³⁶

Even within the I.H.S. hospitals, Indians are often given second rate care. Some hospital pharmacies do not stock many of the newer drugs which are available elsewhere. The physicians are typically young and inexperienced (though often dedicated and conscientious), and very limited funds are made available for them to call in specialists or more experienced doctors for consultation and assistance. Furthermore, there is an almost complete turnover in professional staff every two years, which reinforces the social and cultural isolation of the facility from the Indian community. Morale problems among the physicians are acute because

35. I.H.S., Justification for Appropriations, FY 1970

36. I.H.S., Justification for Appropriations, FY 1970

of isolation and poor facilities, and compounded by the red-tape and military regimen of the bureaucracy.

III. STATE AND LOCAL SERVICES

In addition to health services available from the P.H.S. Indian Health Service, Indians may also be eligible for services through state Medicaid programs and at local hospitals which have received federal funds through the Hill-Burton Act.

A. Medicaid:

All states except Arizona and Alaska have Medicaid programs in operation at the present time. These programs vary considerably in their eligibility requirements and extent of coverage. (See Appendix VI for summaries of various state Medicaid programs). Those who must be included within the coverage of the state program include everyone receiving financial aid from the state's "categorical" public assistance programs for families with dependent children (AFDC), and for the aged, the blind, and the disabled, along with everyone who would be eligible for such financial assistance except that he does not meet some state requirement prohibited by federal law (e.g. durational

residency requirements), and everyone under age 21 who, except for a state age or school-attendance requirement, would be eligible for AFDC. States may, but need not, include other groups such as the "medically indigent" among those eligible for Medicaid, although California appears to be the only state with a sizeable Indian population which has done so.

Coverage commences from the date of application if eligibility requirements are met as of that date.
 Applications must be processed promptly, and services^{36a}
 furnished with reasonable promptness.^{36b}

States may require recipients to obtain prior authorization for some types of services before expenses will be reimbursed under the plan. While desirable from the standpoint of fiscal control, prior authorization requirements must not be a means of circumventing the federal regulations re promptness, scope of services, and uniformity^{36c} of the plan's operation throughout the state. Prior authorization cannot be denied for a treatment because it is not ordinarily available in the county so long as that treatment may have been provided to other Medicaid participants in the state. Once a course of treatment has been

36a. Within 30 days unless additional medical evidence is required. Handbook of Public Assistance Administration, Supp. D, §3020.2.

36b. 42 U.S.C. §1396 a (a)8; Handbook of Public Assistance Administration, Supp. D. §§3020.6, 3030.5. While some states provide retroactive coverage, persons should, as a rule, apply first to be assured that services will be covered. Persons receiving categorical assistance may be automatically covered in some states and need not go through the formal application procedure.

36c. 42 U.S.C. 1396 a (a) 1; Handbook of Public Assistance Administration, Supp. D. §2230.2.

authorized, the provider must often obtain periodic reauthorizations to guarantee reimbursement from the state, such as after the first five days of hospitalization. Under Goldberg v. Wyman, ___ U.S. ___, U.S.L.W. 4223 (1970), the recipient should be entitled to have Medicaid benefits continued prior to a fair hearing if a cutoff is threatened. Also, any discontinuance of medically necessary treatments by the provider because authorization was later withheld may give rise to a claim for damages for abandonment.^{36d}

States are required to furnish medicaid assistance to eligible persons who are residents of the state who need services while outside of the state if an emergency arises; if their health would be endangered if the services were postponed until they returned to their home state; or if travel to the home state would endanger their health.^{36e} States must also provide coverage for services to its residents rendered outside the state if it is the general practice for residents of a particular locality to use medical resources outside the state, or when the availability of services outside the state makes it desirable for the individual to travel to another state and advance authorization is obtained.^{36f}

State agencies must also facilitate the meeting of medical needs within the state for residents of other states.^{36g}

36d. See 57 ALR 2d 432

36e. 42 U.S.C. 139 a (a)(16); 45 C.F.R. 202.1; Handbook of Public Assistance Administration, Supp. D. §5620.1.

36f. Id. §5620.2.

36g. Id. §5620.3.

These requirements are particularly important to Indians, many of whom live near state boundaries or tend to be transient.

Benefits which are usually provided by the state Medicaid program include in-patient and out-patient hospital services; physician's services whether provided in the office, home, hospital, or elsewhere; nursing, dental, and physical therapy services; nursing-home services for persons over 65; hearing-aids, eye glasses, drugs, and a variety of other services. Many of these are not available at I.H.S. service units. Ambulance services and other transportation expenses to and from the provider must be covered as of July 1, 1970.

Anyone covered by Medicaid must be given free choice among practitioners qualified and willing to accept the individual as a patient, and among qualified medical facilities and community pharmacies. Generally, a recipient will be issued a Medicaid card by the state agency, and will be given services by the physician or facility upon presentation of the card. The physician or facility is usually reimbursed by the state agency directly upon submission of the necessary vouchers.

Any Indian whose claim for medical assistance is denied or is not acted on with reasonable promptness (30 days) can request a "fair hearing". The hearing must be held promptly and a decision must be rendered within 45 days. If there are unusual circumstances, the agency is allowed up to 90 days to render a final decision. The appellant must be given an opportunity to examine all evidence used by the agency in making a decision on his claim, and the agency must provide transportation to and from the hearing if it is to be held a considerable distance from the appellant's residence.

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State and/or local welfare officials administering the Medicaid program are often reluctant to allow Indians, otherwise eligible, to receive Medicaid because they may always receive free service from I.H.S. facilities. Any doubt that Indians are entitled to the same Medicaid services as the rest of the state's population were resolved by H.E.W. in instructions contained in State Letter Number 1031:

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1. Indians shall have the same rights to receipt of medical services...as do all other individuals in the State who meet the State's eligibility requirements.

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- 37. U.S. Department of H.E.W., Handbook of Public Assistance Administration, Supp. D, §§ D-6520, 6530, 6540 and 6550.
 - 38. U.S. Department of H.E.W., Soc. & Rehab. Serv., State Letter No. 1031 (April 18, 1968) (See Appendix VII).

2. In the case of a person who qualifies as an Indian beneficiary, the Division of Indian Health, Public Health Service...may assume residual responsibility for medical care and services not included in the appropriate State plan,...if such Indian chooses to utilize the Indian health facilities, without affecting the eligibility of the Indian under the State's medical assistance or other public assistance program. (Emphasis in original).

Consequently, an Indian's eligibility for I.H.S. services and the availability of these services cannot be considered by the State agency in granting or denying Medicaid to him.

In several states, officials have attempted to restrict eligibility and scope of services for Medicaid to narrower limits than those authorized by the state legislature. Even though the legislature has authorized broader coverage, the agency may seek to limit the program to those presently receiving categorical assistance for budgetary reasons. A permanent injunction has recently been obtained against Iowa welfare officials restraining them from limiting eligibility for the state's Medicaid program to a narrower class of people than the legislature intended.³⁹ Likewise, the state agency cannot reduce the scope of services available under the plan for any reason without obtaining prior authorization for the cutback from H.E.W. and complying with detailed federal requirements for cutbacks. The only basis for denying services available under the state's plan to a beneficiary is that they are not medically needed.^{39a}

In most areas, there has been little or no co-ordination between I.H.S. and Medicaid officials to maximize the availability of health services to Indians

39. Dimery v. Department of Social Services, Civ.No.8-2386-C-1 (D.C. S.D. Iowa) (Clearinghouse Rev.No. 2195) (appeal now pending to Supreme Court).

39a. The National Legal Program on Health Problems of the Poor (U.C.L.A. Law School, Los Angeles 90024) has detailed information available on the federal requirements and their application.

and avoid duplication. Indians who are denied treatments by I.H.S. are seldom told that they may be able to obtain them through Medicaid, and vice-versa. I.H.S. facilities could greatly expand their services by allowing private doctors, dentists, nurses and other professionals to associate with the facility as consultants or CMC vendors and receive the bulk of their fees through Medicaid.

B. Local Services:

Any local hospital receiving federal funds for construction or expansion under the Hill-Burton Program (42 U.S.C. 291 et seq.) must agree that:

"there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, and exception shall be made if such a requirement is not feasible from a financial view point."

Since the Surgeon General is required by the Act to give special consideration to hospitals serving rural communities and areas with relatively small financial resources, many hospitals near Indian reservations will have obtained funds under the Act and be subject to the above requirement. Hospitals are rarely permitted to "opt-out" by showing that such a requirement is not

40. 42 U.S.C. 291c (e)

feasible from a financial view point. The hospital must specifically agree to abide by this requirement in its Application for Project Construction funds (Part I, §P), which is the contract under which funds are provided.

The local hospital's obligation to provide a reasonable volume of free services to persons unable to pay for them is critically important to those persons who are not covered by Medicaid but who nonetheless are "medically indigent". On most reservations, this would include the working poor and "intact families" ineligible for categorical assistance programs. H.E.W. has done very little to enforce these commitments and most hospitals receiving funds have ignored their responsibility under Hill-Burton. A person denied services may have a cause of action against the hospital under the federal statute and funding contract.⁴¹ The National Legal Program on Health Problems of the Poor (UCLA Law School, Los Angeles, California 90024) has model complaints and memoranda available on this issue.

41. See 3 Clearinghouse Review 185 (No.8, Dec. 1969)

IV. POSSIBLE LEGAL REMEDIES

A variety of legal and administrative remedies are available to correct abuses by state and federal agencies dealing with Indian health. To date, few of these have been utilized. The following discussion will focus on these in relation to areas where abuse is most likely to occur.

A. Federal Programs: The Administrative Procedure Act

The Indian Health Manual provides that when services are denied, or presumably when they are assigned low priority, the applicant must be given written notice of the basis for denial. This notice should include "the specific circumstances and facts upon which the priority decision was made," along with the statement, "if you have any information which may affect this decision, you may submit it with a copy of this letter^{41a} for review by the Indian Health Area Director."

The applicant is afforded no hearing, no opportunity to know and meet any evidence against him, and has no way of knowing whether or when the Area Director will consider his request for review. Consequently, every denial of services or assignment of low priority would appear to

41a. Manual 2-1.5C(2)

give rise to a cause of action under the Administrative Procedure Act, 5 U.S.C. §§ 701-706, without the necessity for pursuing administrative remedies.⁴² Since low priority often if not always means the requested services will never be provided, showing that the plaintiff has been aggrieved thereby would not ordinarily be difficult. Note that "sovereign immunity" would be no defense to claims within the scope of the APA even though no constitutional issues are raised, since the APA has been held to "constitute a waiver of sovereign immunity concerning those claims which come within its scope."⁴³

In an action under the APA, the court would not be limited to determining if the administrative decision were supported by substantial evidence. The substantial evidence rule applies only to cases "subject to section 556 and 557 [of the APA] or otherwise reviewed on the record of an agency hearing provided by statute."⁴⁴ 5 U.S.C. §706 (2) (E).

While courts generally seek to avoid de novo hearings, as a matter of deference to agency "expertise", they will be much more willing to permit them where the

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42. See *Norwalk CORE v. Norwalk Redevelopment Agency*, 395 F.2d 920 (2nd Cir. 1968); *Wasson v. Trowbridge*, 382 F.2d 807 (2nd Cir. 1968).
43. *Kletschka v. Driver*, 411 F.2d 436, 445 (2nd Cir. 1969); cf. also *Vitarelli v. Seaton*, 359 U.S. 535 (1959), but see *Cotter Corp. v. Seaborg* 370 F.2d 686, 692, n. 15 (10th Cir. 1966).

agency record provides an inadequate basis for determining if discretion was properly exercised, or where constitutional issues such as denial of due process are raised.⁴⁵ Often the service unit will have no records to support the determination in question. Furthermore, where eligibility for services is at issue, the regulations place the burden on the service unit to obtain additional evidence before denying services in doubtful cases.⁴⁶ The current practice in some areas is to place the burden of proving eligibility on the applicant.⁴⁷ Thus, even if the substantial evidence rule is held to apply, the denial of services in doubtful cases would be an abuse of discretion unless the service unit has assumed this burden of obtaining additional evidence.

44. Sections 556 and 557 apply only to hearings required by sections 553 and 554, i.e. to "rule-making" (§553) and to adjudications "required by statute to be determined on the record after opportunity for an agency hearing" (§554(a)). See *Borden Co. v. Freeman*, 256 F.Supp. 592 (D.N.J.), *aff'd*, 369 F.2d 404 (3d Cir. 1966) cert. denied, 386 U.S. 992 (1967).

45. See *Wasson v. Trowbridge*, *supra*, note 42.

46. 42 C.F.R. §36.12(a); Manual 2-1.2A

47. I.H.S. Phoenix Area Office, Manual Instruction 2-1.1 (11/14/68). ("Applicants must be advised that proof of beneficiary status must be furnished within 15 days or the applicant will be billed for all services provided. During this period, health services may be provided, if medically indicated, to alleviate pain and suffering. If proof of beneficiary status is not furnished, health services may be terminated...and a bill for services shall be tendered.").

Under the APA, a broad range of I.H.S. decisions regarding priorities and scope of services might be challenged by individual or class actions.^{47a} The denial of services such as dental care, mental health care, ambulance service, eye glasses and hearing aids might be challenged as arbitrary on a variety of grounds. One Indian's hearing defect may be substantially more of a long-term burden (especially if he is a student) than another's temporary sore throat for which he is allowed treatment. The refusal of the service unit to give the former a hearing aid or treatments could be challenged as an abuse of discretion, denial of equal protection and a violation of the statutory mandate. At some service units, the inadequacy of the I.H.S. program in general could be attacked on similar grounds. The program, priorities and scope of services could also be attacked on the grounds that I.H.S. officials have failed to consult with the Indian community, which is a violation of the I.H.S. Guidelines on Tribal Participation.⁴⁸

Any doubt that the Indians, as intended beneficiaries of the I.H.S. program, have standing to challenge the arbitrary or inadequate administration of the program was resolved by the recent Supreme Court decisions in

47a. While §§702-704 of the APA have been held to confer subject-matter jurisdiction on the district courts to hear such cases, Sikora v. Brenner, 379 F.2d 134 (D.C. Cir. 1967), the Supreme Court has expressed no view on this question and it may be wise, where possible to allege other jurisdictional grounds such as 28 U.S.C. §1331. See Tooahnippah (Joombi) v. Hickel ___ U.S. ___, 38 U.S.L.W. 4323 at note 9 [April 27, 1970].

48. See Appendix IX. Consultation is also mandated by Manual Section 1-3.4B, supra. Note 12.

Barlow v. Collins, ___ U.S. ___, 38 L.W. 4195 (1970), and Association of Data Processing Service Organizations, Inc., v. Camp, ___ U.S. ___, 38 L.W. 4193 (1970). Barlow held that the right of judicial review of agency actions should be inferred where a congressional intent can be found to protect the interests of a class of which the plaintiff is a member; "in such cases, unless members of the protected class may have judicial review, the statutory objectives might not be realized." Id. at 4197. Standing to seek judicial review, according to the Data Processing decision, arises if the interest sought to be protected by the plaintiff is arguably within "the zone of interests to be protected or regulated by the statute or constitutional guarantee in question." Id. at 4195.

B. Federal Tort Claims and Tucker Acts:

An individual Indian (or a class where appropriate under Rule 23) suffering damages as a result of the negligence of an I.H.S. officer or employee acting within the scope of his employment may claim damages from the United States under the Federal Tort Claims Act, 28 U.S.C. §§2671-2680. The claim must be presented to the agency and denied (or not acted upon within six months) before suit is filed. 28 U.S.C. §§2672, 2675 (Supp.). Jurisdiction arises under 28 U.S.C. §1346 (b). The official or employee is personally liable for his torts in the

course of his employment (see 67 C.J.S. Officers §§125-130) although the government may substitute its own liability for that of the employee. 28 U.S.C. §2679 (b,c).

The agency itself is not subject to liability under this Act, but its officials may be joined if the court has independent jurisdictional grounds for joinder (e.g. 28 U.S.C. §1331). This is important where, for instance, an individual sues for damages for the negligent choice of a CMC vendor by I.H.S. officials. The officials could be joined under §1337 and restrained from contracting with incompetent vendors as a violation of their duty under 42 U.S.C. §2001, ⁴⁹ et seq. (See Appendix IV).

I.H.S. physicians and facilities are held to the same standards of medical practice as those generally prevailing in the private areas. *Schwartz v. United States*, 230 F.Supp. 536 (D.C. Pa. 1964); *Jackson v. United States*, 182 F.Supp. 907 (D.C. Md. 1960); *United States v. Gray*, 199 F.2d 239 (10th Cir. 1952). In building a negligence case, it will often be helpful to use the detailed instructions issued by the Area Office concerning proper treatments and procedures to show the duty of care and breach.

49. 28 U.S.C. §1337, granting federal jurisdiction over actions arising under laws regulating commerce, would be appropriate here since Congress enacts statutes affecting Indians pursuant to the Commerce Clause. *Williams v. Lee*, 358 U.S. 217, 219, n.4 (1959).

Even though no negligence can be shown, the plaintiff may be able to recover damages for breach of contract under the Tucker Act, 28 U.S.C. §1334 (a) (2), where the claim does not exceed \$10,000.⁵⁰ This provision may be useful in situations where the services provided by I.H.S. are clearly inadequate, e.g. a dentist's extracting all of a child's teeth which he finds are beyond repair, but not filling the others. The I.H.S. may seek to justify such procedures as being the most efficient use of the scarce dental resources available. However, the child may claim that by undertaking to provide dental care to him, the I.H.S. is under at least an implied obligation to provide adequate care. By failing to do more than pull the dangerously decayed teeth, I.H.S. has breached this obligation and the United States is liable for damages.

This provision has also been used with considerable success in the water and sanitation area. (See Appendix IV). By undertaking to provide water and sewage, I.H.S. has a contractual duty to provide an adequate water system. In this area, the plaintiff can usually point to an express contract or writing, an implied covenant of which is that the system will be adequate for his reasonable needs.

50. Claims over \$10,000 must be filed in the Court of Claims, 28 U.S.C. §§1491, 1505.

Joining an action against a third party (e.g. agency official) along with the claim against the United States for breach of contract may be more difficult here than with the Tort Claims Act. See *United States v. Sherwood*, 312 U.S. 534 (1941). It should be much less of a problem where the third party is a government official, *French v. United States* 180 F.Supp. 773 (E.D. N.Y. 1960), and where there is an independent jurisdictional basis for joinder of the third party. *Cramp Shipbuilding Co. v. United States*, 195 F.2d 848 (3rd Cir. 1952). Note, however, that the action can always be severed if joinder is ruled improper.

In many instances, the attorney may be able to obtain I.H.S. services for his client through informal channels. The local service unit director is usually a non-professional civil servant, and his own medical opinion of the client's need for treatment is not being disputed. He may be willing to overrule the attending physician to avoid controversy and litigation, and grant the desired services. If the client's eligibility is in question, his reputation as an Indian in his community along with other factors "indicative of Indian descent" should be stressed.⁵¹

51. 42 C.F.R. §36.12 (a) (2); Manual 2-1.2A (5)

Where the need for services is immediate, treatment should be provided even though eligibility is in doubt.⁵² This requirement does not appear in the Manual, and the local director may not be aware of it.

Informal appeals may also be taken to the Area Director using the same arguments where the local director will not acquiesce.

B. Medicaid Remedies:

As with other programs established by the Social Security Act - Aid to the Blind, Aid to Families with Dependent Children, Aid to the Disabled - the state Medicaid program must conform to detailed federal requirements established by the Act and the regulations issued thereunder which are contained in Supplement D^{52a} of the Handbook of Public Assistance Administration. If the state program does not conform to the federal requirements, it is well settled that private plaintiffs have standing to sue to enjoin its operation. *King v. Smith*, 392 U.S. 309 (1968). Some of the more important

52. 42 C.F.R. §36.12 (b) (2).

52a. Also in 45 C.F.R. §202 et seq.

requirements were discussed above.⁵³

The right of eligible individuals to receive public assistance benefits is protected by the Due Process clause of the Fifth and Fourteenth Amendments according to King v. Smith, ⁵⁴supra. The denial of these benefits to a person eligible under the federal requirements is a denial of equal protection and due process and federal courts have jurisdiction to enjoin the denial. Shapiro v. Thompson, 394 U.S. 618, 89 Sup. Ct. 1322 (1969); Kelly v. Wyman, 294 F.Supp. 893 (S.D. N.Y. 1968). Jurisdiction also arises under 28 U.S.C. §1343 to redress the rights guaranteed by the Social Security Act and the Civil Rights Act, 42 U.S.C. §1983.

The claim of conflict of the state practice or regulation with the federal requirements can be heard under the court's pendent jurisdiction to the constitutional grounds,⁵⁵ and under the general federal question section,⁵⁶ 28 U.S.C. §1331. (But cf. Rosado v. Wyman, 38 U.S.L.W. 4266 (U.S. April 6, 1970))

53. See text at note 36, ^(a)supra. Of critical concern to Indians are the requirements that services available under Medicaid are equal and uniform throughout the state, 42 U.S.C. 1396 (a) (1), Handbook, Supp. D. §2230.2; that the local fee standards be such as to enlist sufficient numbers of practitioners and specialists to provide the needed volume of services in the locality, Handbook Supp. D §5320; and that transportation expenses to and from the vendors of services be covered, 45 C.F.R. §§249.10 (b) (4), 249.15. This latter requirement is implicit in the law now, where services are not available in the recipient's locality, and becomes an express requirement for state programs after July 1, 1970.

Obtaining preliminary relief may be of vital concern to the plaintiffs and their class, and this may be somewhat easier in the Medicaid area than in other welfare litigation because of the potential for greater injury to the plaintiffs than the defendants if such relief were not granted.⁵⁷

The state cannot avoid a preliminary or permanent injunction on the grounds that it would force the legislature to appropriate additional funds from the public treasury. Pure budgetary considerations cannot justify arbitrary classifications, or other unconstitutional state actions.⁵⁸

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54. See, e.g. *Heywood v. Public Housing Administration*, 238 F.2d 689 (5th Cir. 1956); *Dixon v. Alabama State Board of Education*, 294 F.2d 150 (5th Cir.), cert. denied, 368 U.S. 930 (1961).
 55. *United Mine Workers v. Gibbs*, 383 U.S. 715, 725 (1966).
 56. The action arises under the Social Security Act, and in most, if not all, instances the damages suffered as a direct long-term result of the denial of services will exceed \$10,000. See *NAACP v. Patty*, 158 F.Supp. 503, 520 (D.Va. 1958); *McNutt v. GMAC*, 298 U.S. 178 (1935); *Bishop Clarkson Hospital v. Reserve Life Insurance Co.*, 350 F.2d 1006, 1008 (8th Cir. 1965).
 57. See Appendix VIII: Plaintiffs' Supplemental Memorandum of Law, *O'Reilly et al. v. Wyman, et al.*, 69 Civ. 2780 (S.D.N.Y. filed July 14, 1969) (Preliminary injunction granted July 2, 1969, by Motley J.; dissolved September 22, 1969 by three-judge court on grounds that sufficient conflict of state regulation with federal requirements had not been shown, CCH Pov. L.R. §10,894 (Feb.9, 1970)).

In addition to the federal remedies, the attorney may utilize traditional mal-practice remedies against negligent vendors of Medicaid services, and the "fair hearing" remedy to challenge agency decisions.⁵⁹ The latter is useful where factual questions concerning eligibility or need for services are involved, but often worthless where agency policies or regulations are at issue.

V. ROLE OF THE TRIBE

One of the most glaring failures of I.H.S. has been its refusal to allow or encourage the Indians to play an active role in the programs which affect them. While enjoying more success than the B.I.A. in obtaining congressional appropriations for Indian health, I.H.S. has done little to reverse the paternalistic approach to delivery of health services which it inherited from the B.I.A.. I.H.S. remains an alien impersonal program to many Indians. It treats the patient's body but ignores the social and cultural components of the illness.

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58. Shapiro v. Thompson, supra; Green v. Department of Public Welfare, 270 F.Supp. 173 (D.Del. 1967). See generally, O'Reilly, et al. v. Wyman, et al. supra. (Documents available from Clearinghouse, #2150).
59. See text at note 37, supra. If services are discontinued by the vendor, the patient may have a damage action for "abandonment" against him. See 57 ALR 2d 432.

The need for broader participation by Indian communities is apparently recognized by I.H.S. officials⁶⁰ in Washington. Thus, it is likely that a tribe seeking to assert a greater role in I.H.S. policy and programs would have some success, despite the intransigence of lower-level bureaucrats.^{60a} Tribal officials might demand that they be consulted before decisions on priorities and programs are made, and that I.H.S. provide them with information and statistics from which they could make their own determination of how resources could be most efficiently allocated. Many tribes, at the urging of I.H.S., have set up health committees in recent years which have been for the most part impotent in asserting a tribal voice in service unit policies. This is not surprising, since service unit and area officials have ignored them in making decisions on programs, and have made no effort to inform them of alternative funding possibilities.

In addition to demanding prior consultation in I.H.S. decision-making, tribes may demand a direct role in various I.H.S. activities. They could take over the supervision of all water and sanitation construction; obtain CMC funds to provide ambulances, community education and other social services; and funds to construct health

60. See Guidelines for Tribal Participation, Appendix

IX.
60a See Indian Health Care Improvement Act

60b See P.L. 95-626

^{60b}
centers in outlying areas.

Indeed, there is no legal impediment to the tribes' assuming direct responsibility for overseeing all I.H.S. programs within their jurisdictions through a tribal board of health or other arrangement. In this way, the health resources available to the tribe through I.H.S., Medicaid, D.N.A.P. and other programs could be co-ordinated to avoid duplication and maximize their impact on the health of the population. ^{60c} The police power of the tribal government could be utilized to pass and enforce comprehensive health and sanitation ordinances. ⁶¹

Funds are available to the tribes to construct and operate a variety of health facilities such as old-age homes, day care centers for pre-school children, and clinical facilities through several programs. At Pine Ridge, a nursing home was built by the Oglala Sioux Housing Authority with funds from the Housing Assistance Administration. The Housing Authority leases the building to the Pine Ridge Settlement House, Inc., a non-profit South Dakota Corporation which was organized by the tribe. The corporation manages the home, furnishes the rooms, kitchens, etc., and provides the necessary services to the sub-tenants, and charges the sub-tenants the amount allocated by the Old-Age Public Assistance Program of South Dakota for food and shelter (about \$75.00 per

^{60c} See P.L. 93-638

⁶¹ State and local health and sanitation laws have

month per person).

Funds are available to reservation Community Action Programs to set up Community Health Aide programs which employ Indians to disseminate information on health and hygiene, and assist persons needing medical attention. I.H.S.I. also has funds available for programs to combat alcoholism and to supplement the diets of expectant mothers before and after childbirth.

In the area of nutrition, the tribe can take steps to insure broader distribution of surplus commodities or food stamps. This may be done through the community health aides and other tribal agencies spreading information on the availability of the food program. The tribe may demand that existing programs be expanded by the state agency, or force expansion by litigation where the program does not meet minimum federal standards. Many state operated schools on Indian reservations do not as yet have free lunch programs as required by U.S.D.A. regulations. (See 42 U.S.C. §§1751-1760; *Marquez v. Hardin* Civ. No. 51446 (U.S.D.C., N.D., Cal.) CCH Pov. L.R. §10, 393). This violation may be

recently been ruled inapplicable on Indian reservations by the Solicitor of the Interior Department. U.S. Dept. of Interior, Solicitor's Memorandum No. M36768, (Feb. 7, 1969).

attacked by injunction or mandamus. It may also be possible for the tribe to assume jurisdiction over the distribution of food stamps or commodities from the state agency where the latter has been derelict in meeting U.S.D.A. requirements.

The tribes can take the initiative in having the U.S.D.A. Supplemental Food Program implemented on their reservations to provide free dietary supplements to Indians especially vulnerable to malnutrition. All Indians eligible for I.H.S. services are eligible to receive food under this program. U.S.D.A. provides the food, I.H.S. locates and certifies the individual who are eligible to participate, and provides monthly check-ups to those participating. The state or tribal agency presently distributing U.S.D.A. surplus commodities handles the transportation and distribution of the food on the reservation.

Because of the costs involved, many state agencies have been reluctant to implement the program. The tribes may, with their own or Q.M.A.P. funds, set up and operate their own distribution procedures for the commodities. C.H.B. community health aids and/or I.H.S. personnel can issue the required "prescriptions", and see to it that recipients in need of medical attention obtain it as a condition of participating in the program. Needless to say, the potential impact of this program on the health and nutrition of the Indian communities is enormous.

62. See Appendix V. The National Council on Hunger and Malnutrition has information on applications and funding procedures for this and other federal programs relating to nutrition. Their address is 1211 Connecticut Avenue, Washington D.C. 20036.

Flandreau Santee Sioux Tribe

Community Health Representative

Flandreau, S. D. 57028

Box 292

Phone 997-3291

May 24, 1983

U.S. Senate Select Committee of Indian Affairs:

The P.L. 94-437 has been a very significant law, as provided in the Act, Congress established a national goal of raising the status of health for Native American Indian people to the highest possible level and also stressing that Indian people should participate in the planning and management of their health services.

The Federal Government has a responsibility to Indian people of providing the best health care possible to Indian people. Not only does the government have a special relationship that is unique with Native American people that it does not have with any other group of people in the United States.

Although progress has been made toward the goals of 94-437 Act, there remains much work to be done and it seems that in the time of some progress, we now find ourselves facing with the one step forward, perhaps two steps backward.

We must hold the special responsibility of the government and it's legal obligations to the Native American people in its proper perspective and that our Congressmen who make laws - not break anymore of the legal laws to the Indian people.

I have seen Indian people, living on reservations where there is 80-90% unemployment, who have no recourse to a third party insurance plus barely struggling for survival. I have seen poor living conditions which also contribute to poor health. I have seen hunger in families where they eat mostly starch because they can stretch macaroni, rice, beans and flour to go a long way. I have seen many Indian people who have a high percentage of diabetics, people dying from cirrhosis of the liver, cancer and a big problem of alcoholism among our people. I have seen the substandard housing they live in. It seems to me that Indian people have always struggled to survive and even so in the past days of * glory.

It is with deep concern that in every area we continue to battle for the right things for our people.

The area of Title I Indian Health Manpower. Congress enacted programs to increase the numbers of Indian people in the health
CONTINUED

professions. We need to continue to see our people joining the forces of health professions and that they have the opportunities to do so.

The area of Title II - Health Services. There is such a backlog in Indian health care services and people dying needlessly every day and it should be the will of all people to preserve life for life is a most precious gift from God.

The area of Title III - Health Facilities - there has been progress in some areas but yet I have seen many facilities so lacking and needing renovation and construction. The Indian population is increasing at 2.9% (18,000 every year) that these facilities will continue to be a need.

The area of Title IV - Access to Health Services: This enables IHS to collect Medicare/Medicaid. Already IHS is backlogged in almost every area and yet the administration is considering offsetting IHS appropriations in Fiscal Year 1984 by some \$40 million in Medicare/Medicaid collections. We could use this \$40 million in saving the lives of our people that without services will surely die.

The area of Title V - Health Services for Urban Indians - They are our people. They have a home base in one of the already over crowded reservations, and deserve health care for they are our people.

No doubt the cut backs are felt by people in all walks of life and perhaps the poorest of the poor do not feel the pain as much. However, our people will survive for they have survived throughout barriers of every kind. In spirit they are strong. They do not ask for other than the necessities to live in good health and striving to see their people happy.

How can you who make the laws and know in your hearts that the government has a special relationship to Indian people and an obligation in treaty rights to them that you can continue to trifle with Indian Policy when it deals with the welfare of health among Indian people?

As this testimony is read, I ask that you consider our people in the dilemma they now exist and put yourself in their place. There is a need to reauthorize the 94-437 Act in such a way that this bill will continue to strive to provide the best possible health care to Indian people.

May the Lord's presence, be there among you, may He cause you to stop, meditate and pray. May you search your hearts for you are not dealing with a number of statistics but you are dealing with human beings with living souls, and we leave this with you that God will impress your hearts the needs of our people.

Respectfully Submitted,

Pearl Wakeman

Pearl Wakeman

George J. Allen

*Terrell Chairman
American Indian
Society*

Flandreau Santee Sioux Tribe

Community Health Representative

Flandreau, S. D. 57028

Box 292

Phone 997-3391

May 24, 1983

U.S. Senate Select Committee of Indian Affairs:

I feel deeply moved when I think of our "InMed" (Indians into Medicine) Program.

Health and education has always been a special interest to me for we want our people healthy and we want to see them educated. I have always maintained that education is our vehicle out of poverty and not only that but how can our Indian people enter into the walks of professional life if they do not have the means and opportunity to do so.

The InMed Program is a reality of a vision by some concerned Native Americans. The vision became a reality and had her birth. The InMed Program has had it's struggles to survive and now again she is struggling to stay alive.

I have followed the InMed Program throughout the years and it's track record more than proves it's worth. These are crucial times and crucial to survival for these times.

In the Title I area Indian Health Manpower, we cannot afford to see a decrease in the number of Indians entering the health professions. How can we see maximum participation of Indians in the planning and management of their health services if they are not qualified in the health areas. I feel very strongly that if the funding for scholarships of the Indian Health Care Improvement Act does not get funded it will be a great disappointment to all Indian people for once again a vision that became a reality has vanished for we dare dream dreams, we seek visions and hope for reality. InMed has been a vision and a reality.

We continue to have a dire need for doctors, nurses, dentists, and other health professionals in our Indian health services.

InMed has been a unique program for Indian people interested in entering the health fields. They are unique in that they understand the family support role and cultural system of Indian people.

InMed has developed summer institutes for our junior high and high school students. Much motivation and challenge has gone into these programs and our youth has been challenged.

It has taken long hours and hard work on the part of the InMed staff and the interest and concern of Indian people that this program be funded and intact in the 1984 and '85 budget.

It has been a most rewarding experience to witness Indian doctors coming forth from the InMed Program.

We must give our Indian youth the opportunity to study and become health professionals, for who understands the Indian people better than one of its own?

I ask you the U.S. Senate Select Committee of Indian Affairs to deal carefully and wisely in making some crucial decisions for what you decide will affect the lives of Indian people in the days to come.

Respectfully Submitted,

Pearl Wakeman

Pearl Wakeman,

George T. Allen (Chairman) *2 Envision Simultaneous*

Flandreau Santee Sioux Tribe

Community Health Representative

Flandreau, S. D. 57028

Box 292

Phone 937-3891

May 25, 1983

U.S. Senate Select Committee of Indian Affairs:

I feel that it is very important that we continue to write letters supporting the C.H.R. Program.

The CHR Programs throughout Indian Country is vital to our people. Without these CHR Programs the health status of Indian people would be in a worse dilemma. They have been the vital link between the professionals and the Indian people.

The CHR Program continues to be one of the most vital and needed tribal health programs. I am sure all tribes supported the CHR Programs and will continue to do so.

We want to see them included on the 1984 and 1985 budget. As you make your recommendations, please do not trifle with the health of Indian people. They are precious to us and deserve to live to a ripe old age.

"True wisdom starts with a heart full of faith, not a head full of facts."

Pearl Wakeman

Pearl Wakeman

George T. Little

*Tyler Chairman
Flandreau Santee
Sioux Tribe*



BOX 173
GRAND FORKS 58202
PHONE 777-3037

TO: Honorable William Cohen
United States Senate
Senate Select Committee on Indian Affairs

FROM: American Indians into Medicine Program (INMED)
School of Medicine
University of North Dakota
Grand Forks, North Dakota

Hearing Date: February 26, 1982

WITNESS: Elizabeth Yellow Bird Demaray, Assistant Director
American Indians into Medicine Program (INMED)
Box 173 - University Station
Grand Forks, North Dakota 58202

REQUEST:

The INMED Program is requesting your consideration for its continuation as a line item in the Indian Health Service budget with the ability to award new scholarships each year. The phase out of the manpower programs and scholarships comes at a time when the quality and quantity of qualified applicants has started to reach a level to be cost effective. Indian medical students still have the highest drop-out rate in the nation in medical school, hence, the need for support programs such as INMED. The five first year positions in our medical school for Indian applicants and the tribal appointments of representatives to our Advisory Board to set tribal policy for the INMED Program are unique. Please let us continue to serve.

STATEMENT

Thank you for this opportunity to appear before you. My name is Elizabeth Yellow Bird Demaray. I am the Assistant Director of the Indians into Medicine Program, University of North Dakota School of Medicine. I am here in behalf of INMED and its tribally appointed Advisory Board to request your consideration for the Program's continuation as a line-item within the Indian Health Service budget for Fiscal year 1983. Our request is for \$720,000, the funding level at which we were appropriated in FY 81. However, we would remain at the decreased funding level of \$200,000 for our Section 102 budget allowances which cover both operational and support services for our Health Professions Recruitment program. (See Appendix: Tab C)

During this current fiscal year INMED has continued to increase its Program and student support services - as requested by our Advisory Board, the medical school and our students. We have attempted to accomplish these activities in spite of the severe cuts to our Section 102 budget. For instance, through a communique to Congress in 1981, IHS indicated that INMED would be allowed to increase our student enrollment to 62 students beginning fall semester 1981. On that basis INMED increased their qualified applicant pool in order to reach these new Program enrollment numbers and are awaiting their acceptance by IHS. The added student scholarships, in addition to increased student educational and living costs, rising inflation, and directives by the IHS Title I offices which increases our number of administrative procedures have necessitated the request to reinstate our part of the budget that would cover these expenses. We also ask that the Program's budget categories remain as separate line-items for all sections of Title I so that INMED's "total program" concept and a more efficient cost accounting process be maintained. (See Appendix: Tab C)

INMED has proven that it can produce fully qualified medical school candidates and successful medical school graduates, as well as nurses and other health personnel. Since our first medical graduate in 1976, INMED has produced twenty-eight health professionals; twenty-five physicians, one dentist, one nurse, and one Master of Public Health (MPH). By 1985, INMED will have graduated an additional twenty-seven professionals. (See Appendix: Tab A) The current number of medical graduates alone make up approximately 25% of the total number of physicians who have identified themselves as Native American. Of the twelve health professionals who are now practicing medicine, nine are working or have worked with Indian Health Service or in an IHS contracted program or facility. (See Appendix: Tab A) The commitment by the UND medical school to offer five positions annually to entering freshmen students has been instrumental toward INMED successfully placing such numbers.

INMED's results have been unparalleled thus far. While achieving these accomplishments INMED has made every conscious effort to remain cost effective. The Program has kept its administrative costs below 30% of the total Program budget. The remaining 70% has been programmed for functions oriented toward direct services for the students of INMED. INMED's cost for educating one physician is well below the national average cost of \$100,000 as estimated by various medical schools and medical organizations. The Program's annual student retention rate has been maintained at 80% or better. INMED has also

STATEMENT, continued

been invited by the UND medical to help plan and implement reservation based residency programs, thus further impacting health care for Indian tribes.

INMED could not have accomplished their goal without the faith and determination that has been, and continues to be, demonstrated by Congress. One of the latest acts was shown by Senator Andrews from North Dakota; his amendment allowing unexpended annual monies from Indian Health Service Title I scholarships be re-programmed for new student applicants rather than be returned to the U.S. Treasury. The results of this amendment will not only afford increased participation by INMED and other Indian scholarship recipients, but will allow those earmarked monies to be used as intended by Congress.

INMED's request to remain within the purview of the Indian Health Service comes after some investigation of alternative sources of funding for Indian education. We have found a lack of alternatives for funding health manpower scholarship and training programs. Thus, we wish to make Congress cognizant of that fact and of the importance to retain Title I of The Indian Health Care Improvement Act and other enabling legislation that provide any of the remaining means by which Indian Health Service can augment the inadequate number of health professionals who, because of the same cultural background, are more likely to stay and serve Indians.

Through your continued support and the support and cooperation we have received from the university, the Indian tribes and Indian organizations such as NTCA, NCAI, NIEA, and NIIHR, we hope to remain as a viable means to provide the quantity and quality of health services to the American Indian people that all Americans deserve.

INTER-TRIBAL COUNCIL OF MICHIGAN, INC.

405 E. FASTERDAY
SAULT STE. MARIE, MICHIGAN 49783
906-632-6896

MEMORANDUM

RECEIVED

MAY 19 1983

Chairmen - Minnesota, Wisconsin, Michigan & Iowa Tribes

Gary W. Deuman, Steering Committee

The Minnesota Chippewa Tribe

Great Lakes Inter-Tribal Assembly - May 24, 25, 1983

May 17, 1983

The preparations for the Great Lakes Inter-Tribal Assembly are almost complete. I am attaching a tentative agenda for the assembly. For this assembly, as in the last one, we wish to limit the speakers in order to allow more time for discussion of the issues and concerns of the Great Lakes Region Tribal Chairmen.

The Bureau of Indian Affairs "Policy and Issues Workshop" will be held on May 23, 1983. John Fritz, Deputy Assistant Secretary, U.S. Department of the Interior, will attend this meeting only. (This is a change from the previous letter that I sent.) The Tribes are encouraged to attend this important workshop and meet with Mr. Fritz and other Bureau personnel. A meeting room has been set aside for individual consultation between Tribal Representatives and Bureau personnel. The schedule for these consultations will be set at the workshop.

The Indian Health Service has provided funds to assist the Tribes in a portion of the expenses. Two days per diem (\$100.00) will be paid to the Chairman or designated Tribal Representative of each Tribe. The remaining expenses will be paid by the Tribe.

The room rates at the Ramada Inn for this assembly will be \$28.00 plus tax for one person, and \$34.00 plus tax for two people. Your reservation(s) can be made by calling the Ramada Inn at (906) 635-1523. Please state that you will be a part of the Great Lakes Inter-Tribal Assembly.

There will be a \$8.00 registration fee which will provide participants with a ticket to the banquet and dance, which will be held on May 24, 1983, starting at 6:00 p.m. The banquet will feature prime rib. There will be a door prize awarded during the evening.

We hope to see all Tribes in attendance.

If you have questions, please call me at (906) 632-6896.

ac

cc: Steering Committee

GREAT LAKES INTER-TRIBAL ASSEMBLY
WISCONSIN - MINNESOTA - MICHIGAN - IOWA

"Strength In Unity"

May 24, 25, 1983

RAMADA INN

Sault Ste. Marie, Michigan

AGENDA

Monday - May 23, 1983

4:00 p.m. - 7:00 p.m.

Early Registration
Main Lobby, Ramada Inn

Tuesday, May 24, 1983

8:00 a.m.

Registration
Main Lobby, Ramada Inn

9:00 a.m.

CALL TO ORDER
A. Introduction of Chair and
Co-Facilitators
B. Opening Ceremony
C. Rules of Order
D. Acceptance of Agenda
E. Roll Call
F. Opening Remarks
G. Welcoming Address
H. Resolution Committee Selection

9:50 a.m.

Break

10:00 a.m.

OPEN ASSEMBLY
Follow up of Policy and Issues
Workshop

Bureau of Indian Affairs
Possible Discussion Topics:
A. Proposed Realignment of
Bureau of Indian Affairs
B. Jobs Bill
C. Indirect Cost
D. Housing Issues
E. Roads Issue

12:00 - 1:30 p.m.

Lunch Break

Tuesday, May 24, 1983 (continued)

1:30 p.m.

RESUME OPEN ASSEMBLY

Update on Indian Health -
John Buckanaga

Possible Discussion Topics:

- A. Eligibility criterial for medical facilities
- B. FY'84 Budget
- C. Closing Clinics & Facilities
- D. Health delivery & 638 proc

3:00 p.m.

Break

3:15 - 3:45 p.m.

Presentation: Inter-Tribal
Hunting and Fishing Commission
Jim Schlender

3:45 p.m.

Discussion: Other Topics

4:45 p.m.

END SESSION

6:00 p.m. - ?

Banquet & Dance
Bingo Building
Shunk Road
Sault Ste. Marie

Wednesday, May 25, 1983

8:00 a.m.

RESOLUTION COMMITTEE MEETING
Fireside Room

9:00 a.m.

Press Conference - Fireside Room

9:30 a.m.

OPEN ASSEMBLY

- A. Opening Remarks continued
- B. Discussion
- C. Motions and Resolutions

12:30 p.m.

Closing Remarks & Adjourn Meeting



United States Department of the Interior

OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20240

RECORDED

MAR 20 1983

The Minnesota Chippewa Tribe

MAR 23 1983

Dear Tribal Leader:

Last spring we initiated a new form of consultation by holding "Policies and Issues Workshops" with tribal leaders at various locations in Indian Country. We feel the workshops were beneficial and helpful. On many occasions, during the past year, we have drawn on the discussions which we had with tribal representatives at the workshops and decisions have been made on what we heard.

We are planning another series of workshops this year, starting the latter part of April and continuing through the month of May. Attached are copies of our tentative schedule as well as a list of issues and/or policies to be discussed. Either myself or Deputy Assistant Secretary Fritz will be present at each of the locations as we feel it is essential that the tribal leaders be able to talk face-to-face with us on critical and demanding issues.

Your Area Director will notify you of the exact time and location as soon as those arrangements have been made.

Sincerely,

Assistant Secretary - Indian Affairs

Attachments

POLICIES AND ISSUES WORKSHOPS

Schedule

<u>Date</u>	<u>Areas</u>	<u>Locations</u>	<u>Assistant Secretary</u>
April 21	Sacramento		Fritz
April 25	Juneau		Fritz
April 29	Portland		Smith
May 9	Billings		Fritz
May 13	Navajo		Smith
May 16	Phoenix		Smith
May 17	Albuquerque		Smith
May 19	Anadarko and Muskogee	Oklahoma City, Ok.	Smith
→ May 23	Minneapolis		Fritz ←
May 25	Aberdeen		Fritz
June 2	Eastern	Washington, D.C.	Smith

POLICIES AND ISSUES WORKSHOPS

Items to be Discussed

1. Status of Summary of the BIA
2. Review the President's Indian Policy
3. Road Construction
4. The Jobs Bill
5. Short Program Reviews
6. Establishing 1905 Budget Priorities

5760
Calendar No. 3598TH CONGRESS }
1st Session }

SENATE

{ REPORT
No. 98-17

P-17

EMERGENCY EXPENDITURES TO MEET NATIONAL NEEDS

MARCH 7, 1983.—Ordered to be printed

Mr. HATFIELD, from the Committee on Appropriations,
submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 1718]

The Committee on Appropriations, to which was referred H.R. 1718, making appropriations to provide for emergency expenditures to meet neglected urgent needs, to provide supplemental appropriations for advances to the unemployment trust fund for fiscal year 1983, and for other purposes, reports the same to the Senate with amendments and an amendment to the title and with the recommendation that the bill be passed. This report presents an explanation of the contents of the amended bill.

ECONOMIC CONDITIONS GIVING RISE TO THIS LEGISLATION

The Committee reports H.R. 1718 at a time of nearly unprecedented unemployment in this country. Unemployment reached a post-war high in December 1982 of 10.8 percent of the civilian workforce. In that month, over 12 million Americans were seeking jobs, while nearly 2 million more unemployed had given up the search, convinced that they would be unsuccessful.

While the decline in the civilian unemployment rate in January and February to 10.4 percent has cheered the Committee, the 1983 and 1984 unemployment outlook remains dismal. Both Government and nongovernmental economists forecast a very weak recovery by historical standards. The administration predicts real economic

★ (Star pr.at) 17-336 O

**ILLUSTRATIVE PROJECT LIST FOR ACCELERATED MAINTENANCE AND CONSTRUCTION
PROGRAM—Continued**

Craig Brook NFH, Maine	Repair road.
Green Lake NFH, Maine	Repair road.
Yakima NFH, Wash	Repair fish screens.
Hiawatha Forest NFH, Mich	Repair raceways.
Anahuac NWR, Tex	Maintenance/equipment/storage building.
Marion NFH, Ala	Wet laboratory.
Trempealeau NWR, Wis	Rehabilitate main dike.
Baskett Slough NWR, Oreg	Domestic water supply.
Malheur NWR, Oreg	Septic system.
Willamette Valley Complex NWR, Oreg....	Electric and flammable materials storage.
Salt Plains NWR, Okla	Upper Bay levee.
Attwater P. C., NWR, Tex	Road gravel.

IMPROVING NATURAL RESOURCES ON INDIAN RESERVATIONS

The Committee has deleted the \$20,000,000 provided by the House for agricultural, forestry, and range work. Approximately \$85,000,000 is currently available to support these activities.

At the request of the Committee, the Bureau of Indian Affairs submitted a priority list of items to be considered for inclusion in this bill, and additional funds for natural resources was ranked last on this list.

BUREAU OF INDIAN AFFAIRS CONSTRUCTION

A total of \$64,450,000 has been provided for construction projects of the Bureau of Indian Affairs. These funds will support over 40,000 man-months of labor on Indian reservations where the unemployment rate averages 40 percent. Of the funds provided, \$24,450,000 is for the construction of the Hopi High School and related facilities; \$10,000,000 is for the repair and renovation of Bureau-owned jails; and \$30,000,000 is for the repair of existing irrigation systems.

IMPROVING INDIAN HOUSING

The Committee recommends \$30,000,000 for the housing improvement program of the Bureau of Indian Affairs. These funds will provide for the construction of 300 new units and for the rehabilitation of 1,600 existing homes. Twenty-six thousand man-months of labor will be generated by this program. 2-2-60

Rather than distributing the funds according to the "band," the central office shall determine the locations at which the use of rehabilitation funds will preserve the community housing stock by bringing units to standard. New housing money should be targeted to those locations where the construction of between 15 and 50 units would fully satisfy the housing requirements of the community.

B
D

MAILGRAM SERVICE CENTER
PO BOX 217
CASS LAKE, MN 56633

Western Union Mailgram



15541 SI 31002 05/11/83 ICS IPMBNGZ CSP DULB
1E3352252 MGM TDBN CASS LAKE MN 05-11 0425P EST

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MAY 12 1983

The Minnesota Chippewa Tribe

MINNESOTA CHIPPEWA TRIBE BY LS
BOX 217
CASS LAKE MN 56633

Same message sent
to BARKER
PEAK

THIS MAILGRAM IS A CONFIRMATION COPY OF THE FOLLOWING MESSAGE:

1E3352252 TDBN CASS LAKE MN 81 05-11 0425P EST
2023435116
JOHN FRITZ, DEPUTY ASST. SECRETARY OF THE INTERIOR RPT CLY MGM
BY MESSAGE
4150 DEPT OF THE INTERIOR
WASHINGTON DC 20240

MINNESOTA CHIPPEWA TRIBAL EXECUTIVE COMMITTEE HAS GONE ON RECORD
URGE THAT THE JOBS BILL FUNDS BE DISTRIBUTED TO ALL RESERVATIONS
A FORMULA BASIS RATHER THAN TO A SELECTED FEW. WE HAVE BEEN
USED THAT ONLY THE RED LAKE AND WHITE EARTH RESERVATIONS WILL
RECEIVE HOUSING IMPROVEMENT FUNDS AND THAT THE DECISION TO DISTRIBUTE
MONIES WAS BASED ON NEED, UNEMPLOYMENT AND CAPACITY. PLEASE SEND
A COPY OF THE INFORMATION USED TO BASE YOUR DECISION TO ALLOCATE
DS.

ARRELL WADENA, PRESIDENT
THE MINNESOTA CHIPPEWA TRIBE
PO BOX 217
CASS LAKE MN 56633

GET \$1.00

MAILGRAM ORDER

SEND YOUR MAILGRAMS
WILL AUTOMATICALLY DEBIT

AND ASK FOR OPERATOR 35.
TOTAL BILL. OFFER GOOD

ON EACH ORDER PLACED DURING

EST

THEODORE KRENZKE DIR OFC
DEPT OF INTERIOR
WASHINGTON DC 20245 18PM

Western Union Mailgram



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DULB

RECEIVED
MAY 19 1983
The Minnesota Chippewa Tribe

GEORGE GOODWIN
BOX 217
SS LAKE MN 56633

IN ANSWER TO YOUR QUESTIONS CONCERNING THE BASIS OF
DISTRIBUTION OF HOUSING FUNDS IN THE "JOBS BILL", WE WEIGHED
AND APPLIED SEVERAL CRITERIA. IN ACCORDANCE WITH THE DIRECTIONS
FROM CONGRESS, AND THE INTENT OF THE LAW, WE APPLIED THE
FOLLOWING MAJOR CRITERIA TO DETERMINE PRIORITIES:

1. NEED FOR REPAIR, RENOVATION AND NEW HOUSING CONSTRUCTION.
2. THE RATE OF UNEMPLOYMENT IN A PARTICULAR TRIBE OR LOCATION
IN THE AREA.
3. TRIBAL CAPACITY TO MOBILIZE RESOURCES AND DEVELOP AN
EFFECTIVE CONSTRUCTION PROGRAM THAT WILL INCREASE OR
CREATE EMPLOYMENT AS QUICKLY AS POSSIBLE.
4. LOCATIONS WHERE RENOVATIONS AND/OR NEW HOUSING
CONSTRUCTION REQUIREMENTS OF THE COMMUNITY.
5. TRIBES WHICH ARE NOT LIKELY TO RECEIVE ASSISTANCE FROM
OTHER ON-GOING FEDERAL HOUSING PROGRAMS.
6. LOCATIONS WHERE PROJECTS WILL NOT BE HELD UP DUE TO
CONDITIONS SUCH AS, COMPLICATIONS IN OBTAINING RIGHTS
OF WAY, NEED FOR EXTENSIVE ENVIRONMENTAL CLEARANCES,
AND MATERIAL DELIVERY PROBLEMS.

THEODORE KRENZKE DIRECTOR OFFICE OF INDIAN SERVICES BIA
DEPT OF THE INTERIOR WASHDC 20245

(ARS RUEVDEE 0-10-03-001486)
END EST

GNCOMP MGM

RESPONSE FORMAT

1. Provide a breakdown of repair and housing needs for each Tribe in your Area. (Include HIP Categories A, B and D only).

<u>D</u>	<u>CAT A</u>	<u>CAT B</u>	<u>CAT D</u>
BAD RIVER	50	21	44
FOREST COUNTY	30	25	53
LACCOURTEORETTLES	33	38	56
LACOUFLAMBEAU	29	32	66
ONEIDA	30	60	100
RED CLIFF	25	54	32
SOKAOGAN CHIPPEWA	59	42	27
ST CROIX	11	59	41
STOCKBRIDGE MUNSEE	12	13	72
WISCONSIN WINNEBAGO	72	84	147
MENOMINEE	52	475	376
BAY MILLS	85	65	70
GRAND TRAVERSE	4	6	6
HANNAHVILLE	4	4	3
KEWEENAW BAY	100	168	8
SAGINAW CHIPPEWA	2	11	3
SAULT STE. MARIE	48	140	366
BOIS FORTE		20	
FOND DU LAC		30	
GRAND PORTAGE		10	
LEECH LAKE		100	
MILLE LACS		80	
WHITE EARTH		100	
LOWER SIOUX	6	18	20
PRAIRIE ISLAND	4	8	16
SHAKOPEE	3	8	14
UPPER SIOUX	7	9	19
RED LAKE	5	20	189
SAC & FOX	49	37	50

2. Show the rate of unemployment for each Tribe/Location within your Area.

②	% UNEMPLOYED	POPULATION
BAD RIVER	75%	
FOREST COUNTY	66%	
LACCOURTEOREILLES	65%	
LACDUFLAMBEAU	72%	
ONEIDA	38%	
RED CLIFF	75%	
SOKAOGAN CHIPPEWA	88%	
ST CROIX	75%	
STOCKBRIDGE MUNSEE	37%	
WISCONSIN WINNEBAGO	77%	
MENOMINEE	65%	
BAY MILLS	67%	
GRAND TRAVERSE	52%	
HANNAHVILLE	35%	
KEWEENAW BAY	71%	
SAGINAW CHIPPEWA	50%	
SAULT STE. MARIE	62%	
BOIS FORTE	44%	
FOND DU LAC	22%	
GRAND PORTAGE	19%	
LEECH LAKE	23%	
MILLE LACS	23%	
WHITE EARTH	50%	
LOWER SIOUX	90%	
PRAIRIE ISLAND	73%	
SHAKOPEE	25%	
UPPER SIOUX	90%	
RED LAKE	72%	
ABC & FOX	75%	
TOTAL UNEMPLOYMENT RATE IN AREA	57%	WEIGHED BY
		# OF PEOPLE

within your Area on their capability to begin and complete construction work quickly and carry out the intent of HIP and the "Jobs Bill" effectively and efficiently. (Rank by numerical order e.g., (1) Most Capable, (2) Capable and (3) Least Capable).

③	MOST CAPABLE	CAPABLE	LEAST CAPABLE
BAD RIVER	Bad River		
FOREST COUNTY			Forest Co.
LACCOURTEOREILLES		LCO	
LACDUFLAMBEAU		LDF	
ONEIDA	Oneida		
RED CLIFF		Red Cliff	
SOKAOGAN CHIPPEWA			Sokoagon
ST CROIX		St. Croix	
STOCKBRIDGE MUNSEE			Stockbridge
WISCONSIN WINNEBAGO			Wis.-Winn.
MENOMINEE	Menominee		
BAY MILLS	Bay Mills		
GRAND TRAVERSE			Grand Traverse
HANNAHVILLE		Hannahville	
KEWEENAW BAY		Keweenaw Bay	
SAGINAW CHIPPEWA			Saginaw
SAULT STE. MARIE		Sault Ste. Marie	
BOIS FORTE		Bois Forte	
FOND DU LAC			Fond du Lac
GRAND PORTAGE			Grand Portage
LEECH LAKE		Leech Lake	
MILLE LACS		Mille Lacs	
WHITE EARTH	White Earth		
LOWER SIOUX	Lower Sioux		
PRAIRIE ISLAND		Prairie Is.	
SHAKOPEE		Shakopee	
UPPER SIOUX			Upper Sioux
RED LAKE	Red Lake		
SAC & FOX	Sac & Fox		

4. Of the Tribes listed, indicate those in which the following special circumstances exist:

	May receive assistance from other sources	Hold-ups due to complications -- ROW's, environ/clearance, mat. de
BAD RIVER	IHS, HUD	NONE
FOREST COUNTY	IHS	"
LACCOURTEOREILLES	IHS	"
LACDUFLAMBEAU	IHS, HUD	"
ONEIDA	IHS	"
RED CLIFF	IHS, HUD	"
SOKAOGAN CHIPPEWA	IHS, HUD	"
ST CROIX	IHS, HUD	"
STOCKBRIDGE MUNSEE	IHS	"
WISCONSIN WINNEBAGO	IHS	"
MEMOMINEE	IHS, HUD	"
BAY MILLS	IHS, HUD	"
GRAND TRAVERSE	IHS	"
HANNAHVILLE	IHS	"
KEWEENAW BAY	IHS	"
SAGINAW CHIPPEWA	IHS	"
SAULT STE. MARIE	IHS	"
BOIS FORTE	IHS	"
FOND DU LAC	IHS, HUD	"
GRAND PORTAGE	IHS, HUD	"
LEECH LAKE	IHS, HUD	"
MILLE LACS	IHS, HUD	"
WHITE EARTH	IHS, HUD	"
LOWER SIOUX	IHS	"
PRAIRIE ISLAND	IHS, HUD	"
SHAKOPEE	IHS, HUD	"
UPPER SIOUX	IHS	"
RED LAKE	IHS, HUD	"
BAC & FOX	IHS	"

of 15 to 20 units or repair work will satisfy the housing need.

6. Evaluate whether IHS will be able to provide water & sewer construction where needed.

610	6. IHS Participate	5. Number of New units needed	Number of Repairs by HIP Categories	
BAD RIVER				
FOREST COUNTY				
LACOURTEOREILLES				
LACDUFLAMBEAU				
ONEIDA				
RED CLIFF				
SOKAOGAN CHIPPEWA				
ST CROIX				
STOCKBRIDGE MUNSEE				
WISCONSIN WINNEBAGO				
WENOMINEE				
BAY MILLS				
GRAND TRAVERSE		6	A-4	B-6
WANNAMVILLE		3	A-4	B-4
KEWEEANAW BAY				
SAGINAW CHIPPEWA		3	A-2	B-11
SAULT STE. MARIE				
BOIS FORTE				B-20
FOND DU LAC				B-30
GRAND PORTAGE				B-10
LEECH LAKE				
MILLE LACS				
WHITE EARTH				
LOWER SIOUX		20	A-6	B-18
PRAIRIE ISLAND		16	A-4	B-8
SHAKOPEE		14	A-3	B-8
UPPER SIOUX		19	A-7	B-19
RED LAKE				
SAC & FOX				

Categories: 1. Highest Priority, 2. Priority, 3. Lowest Priority, in terms of priority for needs and capacity to implement this program. (No more than 25% of the Tribes in your Area should be placed in Highest Priority).

	Highest Priority	Priority	Lowest Priority
② BAD RIVER	Bad River		
FOREST COUNTY			Forest Co.
ACQUETTEUILLES		LCO	
ACQUFLAMBEAU		LDF	
ONEIDA		Oneida	
RED CLIFF	Red Cliff		
SAAGAN CHIPPEWA			Sokaogon
ST. CROIX		St. Croix	
STOCKBRIDGE MUNSEE			Stockbridge
WINNEBAGO			Wis.-Winn.
WINNEE	Menominee		
BAY MILLS	Bay Mills		
GRAND TRAVERSE			Grand Traverse
HANNAHVILLE		Hannahville	
KEWEEANAW BAY		Keweenaw Bay	
SAGINAW CHIPPEWA			Saginaw
SAULT STE. MARIE		Sault Ste. Marie	
BOIS FORTE		Bois Forte	
FOND DU LAC			Fond du Lac
GRAND PORTAGE			Grand Portage
LEECH LAKE		Leech Lake	
MILLE LACS		Mille Lacs	
WHITE EARTH	White Earth		
LOWER SIOUX	Lower Sioux		
RAVINE ISLAND		Prairie Is.	
SHAKOPEE		Shakopee	
UPPER SIOUX			Upper Sioux
RED LAKE	Red Lake		
SAC & FOX	Sac & Fox		

NEW HOUSING UNIT... that can be undertaken by Tribes listed in 7 above. Also show the estimated costs associated with new construction and repair work.

②	New Units	Cost	Cat A Repairs	Cost	Cat B Repairs	Cost
MAC RIVER ✓	*		10	20.0	7	119.0
FOREST COUNTY	3	114.0	6	12.0	4	68.0
LACOURTEOUILLES	8	304.0	10	20.0	8	136.0
LACDUFLAMBEAU	8	304.0	9	18.0	6	102.0
CHETDA	9	342.0	10	20.0	11	187.0
RED CLIFF	* 5	190.0	9	18.0	9	153.0
SOKOAGAN CHIPPEWA	4	152.0	6	12.0	4	68.0
ST CROIX	4	152.0	7	14.0	7	119.0
STOCKBRIDGE MUNSEE	6	218.0	7	14.0	6	102.0
WISCONSIN WINNEBAGO	9	342.0	14	28.0	10	170.0
WENOMINEE	*				19	378.9
WYOMING	*		20	50.0	16	256.0
GRAND TRAVERSE	6	240.0	4	10.0	6	96.0
WYNNHILL	3	120.0	4	10.0	4	64.0
GREENAWAY	8	320.0	100	250.0	168	2688.0
SAGINAW CHIPPEWA	3	120.0	2	5.0	6	96.0
SAULT STE. MARIE	366	14640.0	48	120.0	140	2240.0
BONIS FORTE					20	300.0
FOND DU LAC					30	450.0
GRAND PORTAGE					10	150.0
LEECH LAKE					100	1500.0
MILLE LACS					80	1200.0
WHITE EARTH	*				25	375.0
LOWER SIOUX	*				12	192.0
PRAIRIE ISLAND					12	240.0
SHAKOPEE	3	106.0			5	30.0
UPPER SIOUX					7	115.0
RED LAKE	* 816	304.0			~~20~~	100.0
SEC & FOX	*		24	60.0	12	240.0
TOTAL	453	17968.0	290	681.0	764	11000.0

May 11, 1983

Acting Superintendent, Minnesota Agency

Housing JOBS Bill Allocation

*Telefaxed
5-11-83*

Director, Office of Indian Services

Attached herewith are revised figures for the six member reservations of the Minnesota Chippewa Tribe. Due to the unusual circumstances whereby the information was requested and responded to by staff, an error was made in the computation of unemployment statistics for each reservation.

I have discussed this with Ronald Peake and he is aware of this submission. Mr. Peake indicated that there may be time for reallocation of funds and I would appreciate a response if there is any change in determination of funding due to the correction of unemployment statistics.

R. H. PEAKE

cc V. Keahna 9 MA
MAO Housing

May 17, 1983

Superintendent, Minnesota Agency

Jobs Bill Program

Minneapolis Area Director

In my attempt to ascertain why only one of our six reservations was funded under the jobs bill program I discovered that erroneous unemployment rates were submitted and subsequently used to determine eligibility. I further determine that the error is not so much attributable to the individual who computed the rates as is the general "crisis management" method used to collect the data which allowed much room for error. I respectfully request, that in the future, initiatives of the magnitude of the "jobs bill program" be coordinated to involve upper levels of management to assure that the proper degree of emphasis, timeliness, and accuracy are duly observed. Furnished herewith are the corrected unemployment statistics for the Minnesota Chippewa Tribe reservations in hope that more funds can be programed to our Agency.

Two other problems we see in this situation are:

1. It was noted on MAO Housing documents that the unemployment rate for the White Earth Reservation was changed from 50% to 82%. This correction was made after the documentation left our office. The question arises why were not the unemployment rates for the other Minnesota Chippewa Tribe reservations changed also, particularly when the Labor Force Reports were furnished for all reservations.
2. With the corrected unemployment rates it appears that other MCT reservations were erroneously excluded from participating in the jobs bill program; some of the reservations feel very strongly that there must be a correction made to allow their participation. At least one reservation has gone on record to demand a moratorium on the distribution of the funding.

In view of the gross error made in determining eligibility of the MCT Reservations to participate in the jobs bill program, I urge immediate action be taken to correct this situation.

Provide a breakdown of repair and new housing need for each tribe in your Area.
(The breakdown must include HUD categories A, B and C only)

TRIBE	CAT A	CAT B	CAT C
Mille Lacs		80	
White Earth		100	
Leech Lake		100	
Fond du Lac		30	
Bois Forte		20	
Grand Portage		30	

AREA TOTAL

Show the rate of unemployment for each tribe/location within your Area.

TRIBE	Potential Labor Force	Unemployed	% Unemployed
Mille Lacs	416	211	50.7 %
White Earth	1,648	1,353	82.0 %
Leech Lake	1,757	1,231	70.0 %
Fond du Lac	652	265	40.6 %
Bois Forte	387	224	57.8 %
Grand Portage	131	45	34.3 %
TOTAL	4,991	3,329	66.6 %

TOTAL UNEMPLOYMENT RATE IN AREA 66.6 %

(Weighted by number of people)

Rank tribes within your Area on their capacity to begin and complete construction most quickly and carry out the intent of HUD and the "Jobs Bill" effectively and efficiently.
(Rank by numerical order, e.g., 1. Most Capable, 2. Capable, 3. Least Capable.)

TRIBE	Most Capable	Capable	Least Capable
Mille Lacs	X		
White Earth	X		
Leech Lake	X		
Fond du Lac		A	
Bois Forte		A	
Grand Portage		A	

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Resources and Services Administration

Public Health Service

Memorandum

INDIAN HEALTH SERVICE

April 19, 1983

Director, Indian Health Service

FY 1983 Current Services Level

Tribal Leaders

RECEIVED

APR 27 1983

The Minnesota Chippewa Tribe

In keeping with the policy of the Indian Health Service (IHS) of fully informing American Indians and Alaska Natives about major issues confronting IHS, the attached table depicts the magnitude of a funding problem facing IHS in FY 1983. This problem results from having to absorb huge cost increases, primarily in the last 3 years, within the appropriation for IHS.

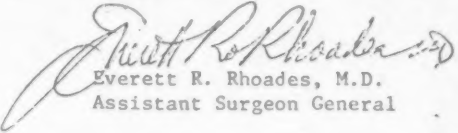
Following is an explanation of each column noted on the table:

- Column 1 - Represents the FY 1982 Appropriation.
- Column 2 - Represents the increase required in FY 1983 to continue the level of services provided in FY 1982.
- Column 3 - Represents the total amount required in FY 1983 to fund the programs at the FY 1982 level.
- Column 4 - Represents the amount of funds, identified by Congress, to be directed to programs not included in FY 1982.
- Column 5 - Represents the total required in FY 1983 to fund programs at the FY 1982 level plus the FY 1983 program increases identified by congressional action.
- Column 6 - Represents the FY 1983 Appropriation.
- Column 7 - Represents the difference between the amounts required in FY 1983 and the amounts available or shortfall.

IHS has informed the appropriate staff in the hierarchy of the Department of Health and Human Services, of the funding problem along with proposed

Page 2 - Tribal Leaders

solutions. We regret any negative impact that these funding problems may cause on the health of American Indians and Alaska Natives. Please feel free to contact your Area Director for additional information.


Everett R. Rhoades, M.D.
Assistant Surgeon General

Attachment

MAJOR THEMES AND ADDITIONAL
BUDGET DETAILS
FISCAL YEAR 1984
INDIAN HEALTH SERVICE

AGENCY: Department of Health and Human Services Functional Code: 550

ending

(\$ in millions)

	1982	1983	1984	1985	1986	1987	1988
CURRENT SERVICES							
Budget Authority	676	688	699	740	783	828	874
Outlays	654	727	746	740	783	828	874
AGAIN BUDGET							
Budget Authority	676	688	653	653	653	653	653
Outlays	654	727	703	670	659	655	654
PROPOSED SAVINGS							
Budget Authority	--	--	46	87	130	175	221
Outlays	--	--	43	70	124	173	220

PROGRAM DESCRIPTION

Indian Health Service (IHS) provides directly, or through contracts with tribes and private health organizations, a range of health care services to Indians and Alaska natives. In 1982, the IHS service population consisted of approximately 900,000 persons (64% of the total Indian population in the United States). Health care is provided free of charge to all Indians who request service and are members of federally recognized tribes, regardless of ability to pay or the availability of employer or other (workmen's compensation, automobile indemnity, etc.) health insurance coverage.

PROPOSED CHANGE

IHS will embark upon an expanded program of collecting for services from insurance and other sources, as a supplement to the appropriations request of \$653 million. Currently, IHS only collects a modest amount (\$20 million) from Medicare and Medicaid. The proposal would result in expanded Medicare and Medicaid collections (\$40 million) and initiate charges to Indians and collect from those who could afford to pay for services, as well as from insurers (such as employers) who cover Indians and their families, e.g., FEHB program, (\$30 million). *Indians will be served by IHS regardless of their ability to pay.*

RATIONALE

The proposed change enhances the resources available to maintain the traditional Federal role in providing health care to the Indians. In addition to the annual appropriations request, however, this proposal will result in increased IHS flexibility to maintain existing health services levels despite the rising costs of medical care. It is appropriate to use third party coverage as an untapped source of additional revenue to the extent that Indians have their own health insurance coverage and other resources.

EFFECTS OF THE PROPOSED CHANGE

In 1984, in addition to \$653 million requested for free IHS clinical services, up to an additional \$60 million could be collected and would be available during the year for health services. Such additional effort would strengthen efforts to improve the health status of Indians, while assuring that third-party payers equitably reimburse for required health services.

NATIVE AMERICANS PROGRAMS

AGENCY: Department of Health and Human Services Functional Code: 506

Funding

(\$ in millions)

	1982	1983	1984	1985	1986	1987	1988
CURRENT SERVICES							
Budget Authority	28	28	30	32	33	35	37
Outlays	32	28	29	30	32	34	36
ADJUDICATED BUDGET							
Budget Authority	28	28	22	19	15	15	15
Outlays	32	28	26	21	18	15	15
PROPOSED SAVINGS							
Budget Authority	--	--	8	13	18	20	22
Outlays	--	--	3	9	14	19	21

PROGRAM DESCRIPTION

The Administration on Native Americans (ANA) funds social and economic development projects for Indian tribes. The purpose of the program is to strengthen tribal government, to encourage the development of local economic activities that provide jobs, and to reduce dependency on welfare while promoting self-sufficiency.

In fiscal year 1983, ANA will make grants to 88 federally-recognized Indian tribes and Alaska Native groups. In addition, ANA gives transitional assistance to 27 tribes who have not been recognized as having a special relationship with the Federal Government. Finally, ANA makes grants to projects assisting urban and rural Indians, Native Hawaiians and national advocacy organizations.

PROPOSED CHANGE

Beginning in the Spring of 1983, Native Americans program funds for federally-recognized tribes and Alaska Natives will be administered by the Bureau of Indian Affairs in the Department of Interior. HHS will retain legislative authority for the program, but will work with Interior to determine program rules and requirements. Financial operations will be handled by BIA in order to improve coordination of Federal assistance to Indian tribes.

The FY 1984 budget proposes a three-year phaseout of assistance to non-recognized groups, special urban and rural projects, Native Hawaiians and national groups. Funding for these groups would be reduced by one-third each year in fiscal years 1984, 1985 and 1986.

RATIONALE

- As the focus of Federal Indian program activity, BIA will be able to coordinate a comprehensive program for Indian development and to eliminate program duplication. Having ANA funds flow through BIA helps achieve the Administration's goals of self-determination for Indian tribes.
- Federally recognized tribes are those with which the Federal government has a unique political relationship, based on historical treaty rights and obligations. These tribes have met stringent constitutional and anthropological tests, documenting this relationship. By definition, non-recognized groups have no continuing claim on special Federal resources, yet they consumed more than 20% of ANA's budget in FY 1982.

Federal funds for Indians should be under tribal control and not pass through service organizations and advocacy groups who cannot best determine tribes' individual needs.

ANA's location in HHS is largely a matter of historical accident dating from the dismantlement of the Office of Economic Opportunity in the early 1970's. This has cut off ANA and its grantees from other Federal Indian programs.

EFFECTS OF THE PROPOSED CHANGE

Federal funding for Indian tribes will be more efficiently managed by having BIA be the central funding source for these programs.

Federally recognized tribes with the greatest need to develop core governmental capacities will continue to receive funds from ANA as well as from BIA's Small Tribes Initiative and Tribal Governmental Services program. A total of \$83 million for these programs is requested in the FY 1984 budget.

Those non-federally recognized tribes who have received ANA transitional assistance may apply to BIA for Federal recognition of their government-to-government relationship. If approved, they will qualify for all Federal Indian programs, for which a total of \$2.3 billion is requested in the President's FY 1984 budget.

FY 1983 Current Services Level
(\$000)

	(Col. 1) FY 1982 Appropriation	(Col. 2) FY 1983 Mandatory A Increases	(Col. 3) FY 1983 Current Services	(Col. 4) Program Increases	(Col. 5) FY 1983 Base	(Col. 6) FY 1983 Appropriation	(Co Sho
ospitals and Clinics.....	\$303,854	\$33,423	\$337,277	\$ 8,125	\$345,402	\$318,055	\$2
Maintenance and Repair.....	8,267	347	8,614	---	8,614	8,267	
Equity.....	15,492	1,704	17,196	7,000	24,196	22,492	
Total Hospital and Clinics.....	\$327,613	\$35,474	\$363,087	\$15,125	\$378,212	\$348,814	\$2
ental.....	19,456	2,140	21,596	105	21,701	20,156	1
ental Health.....	7,874	866	8,740	---	8,740	8,159	
icoholism.....	16,290	1,791	18,081	3,450	21,521	21,207	
ontract Care.....	122,938	13,523	136,461	---	136,461	130,547	5
Total Clinical Services.....	\$494,171	\$53,794	\$547,965	\$18,670	\$566,635	\$528,883	\$37
mitation.....	15,483	1,703	17,186	---	17,186	15,349	1
Public Health Nursing.....	8,455	930	9,385	---	9,385	8,402	
Health Education.....	2,325	255	2,580	---	2,580	2,334	
Community Health Representatives.....	28,800	3,168	31,968	---	31,968	25,000	6
Health Education.....	---	---	---	500	500	500	
Total Preventive Health.....	\$ 55,063	\$ 6,056	\$ 61,119	\$ 500	\$ 61,619	\$ 51,585	\$10
Health.....	8,160	897	9,057	---	9,057	6,000	3
ental Health.....	5,760	702	6,462	---	6,462	5,760	
Health Management.....	2,634	215	2,849	---	2,849	2,634	
Program Management.....	52,017	4,265	56,282	---	56,282	50,721	

Richard B. Meister, MD.
1111 Tartan
Houston, TX 77025

Senate Select Committee on Indian Affairs
U.S. Senate
Washington, D.C.

Sirs:

I am writing this letter in support of the
Indian Health Care Improvement Act (P.L. 94-437).

I am a native American physician who attended the University of North Dakota under the auspices of the INMED program, which is funded by this bill. I believe the state of Indian health care for the present and future to be highly dependent on the support of this bill and continued funding. I am sure you are aware the state of Indian health care has always been well below the average national level of care and has many special problems. In recent years we have made much progress in Indian health care with the help of the Indian Health Care Improvement Act. However, the progress that has been made is only a start and needs continued support to take advantage of the progress that has been made.

The INMED programs stand out far above all others in the progress that has been made toward developing Indian health care professionals to meet the needs of the Indian people. The INMED program has graduated over 50 Indian physicians through their support. The INMED program is not, however, just involved with supporting Indians through medical schools. The INMED program is an outreach program that supports and nourishes potential future students through its contact with highschool students and undergraduates.

It is important that funding be continued on a stable basis if we are to be able to continue the progress we have made and further support the future physicians and health professionals we have been developing in the secondary and undergraduate years. It is the development of these future health professionals that will ultimately have the greatest impact on meeting the Indian health care needs. As with so many social programs, initial funding allows a good start, but then funding is withdrawn and programs halted. The funding for

page 2

INMID has always been a yearly battle, but it has managed to survive. It would be a shame, however, to see such a productive and vital program hampered due to lack of sufficient funding.

I would like to ask for your support and to continue funding on a stable basis for the Indian Health Care Improvement Act and INMID.

Thank you, sincerely,

s/Richard B. Meister, MD.

OGLALA SIOUX TRIBAL HEALTH AUTHORITY, PINE RIDGE, S. DAK.

Mr. Chairman, Honorable members of the Committee, ladies and gentlemen.

My name is Everett Janis and I am an Oglala Sioux Indian from the Pine Ridge reservation in South Dakota. I am a resident of the Medicine Root district and I do want you to know that I very much appreciate this opportunity to appear before you today and to speak of the health problems and needs of my Indian people who reside in this district of which Kyle is the largest village.

The Pine Ridge reservation comprises a large geographical area some 120 miles long and some 60 miles wide. The community of Kyle is located approximately in the center of the reservation. We are also located 55 miles from the community of Pine Ridge. The land area around Kyle is semi-arid and is mostly rolling hills, prairies, and bad lands. Temperatures can range from a low of -30 degrees to a high of 115 degrees fahrenheit.

A recent survey of Kyle shows that 70% of the people still live in sub-standard housing. The average is one to three rooms per house and occupancy is an average of eight individuals per housing unit. The community does have a central water supply and sewage disposal is by sewage lagoon, however, there are still a large number of outdoor facilities being used. Less than 2% of the homes have telephones. Public transportation is non-existent and less than 10% of community residents have access to an automobile. The nearest public transportation is located in Rapid City some 90 miles distant.

The Oglala Sioux Tribal government consists of twenty-seven members from nine different districts, a Tribal president, vice-president, treasurer, secretary and a fifth member form the executive committee. The Oglala Sioux Tribal Health Board which is composed of nine (9) members, is the official liaison entity that works with the U.S. Indian Health Service. Tribal council meetings are held every quarter. Tribal authorities for health are derived from the 1868 treaties, the Snyder Act of 1921; the 1934 Reorganization Act; Transfer Act of 1955; the Indian Self-Determination Act of 1975; and the Indian Health Care Improvement Act of 1976.

Mr. Chairman, today I want to address the committee on our health concerns and needs of the Medicine Root district and Kyle community. What we have at Kyle, is a very small health station that is functionally inadequate to provide comprehensive outpatient and preventive health services to the Indian people in the Kyle service area. The current outpatient facility is a wooden frame structure that measures 24 x 40 feet. It contains 960 gross square feet or about 700 net square feet of usable space. This structure was originally a small two bedroom home that was converted to operate as an outpatient clinic. This structure was built in 1958, does not have a basement and sits on a concrete slab. The clinic has a waiting/reception area that can accommodate only 15 people. On busy days it is not uncommon for people to sit in their cars for several hours waiting to see a physician. This is a common occurrence even during the severe Dakota winters we endure. The facility has two exam rooms, a small lab, storage space in what at one time was a kitchen and two hall closets, one of which has been converted to a furnace room and the other is used for the dispensing of pharmaceuticals and two (2) bathrooms. Through the back door of the clinic is a very small mobile home that has been converted to a two chair dental clinic. The dental clinic has no waiting area nor entrance protection from the South Dakota winters. The clinic is open five days a week and staff other than a physician assistant and clerk must commute from Pine Ridge 55 miles away. All laboratory tests and x-ray exams and patients who need to be hospitalized must be referred to the Pine Ridge facility. No emergency medical services exist, any patient requiring ambulance service must wait until a such service arrives from the Pine Ridge hospital fifty-five (55) miles away. This means two (2) hours must go by before a patient can be treated.

The condition and physical size of this structure is not appropriate to provide health care to Indian people in the Kyle health service area. Hazards from a fire and safety standpoint and extensive high cost maintenance problems makes the continued operation of this facility a real concern for both staff and patients.

Currently, the staff consists of a physician assistant and housekeeper/clerk who reside locally. A physician, clinical nurse, and pharmacist commute once a week from Pine Ridge. A dentist and dental assistant are on contract and must commute from Rapid City some ninety (90) miles distant. Other outreach services are provided on an itinerant basis from the Pine Ridge facility includes Public Health Nursing, Social Services and Environmental Health services.

Major health problems in the Kyle area include diseases of the respiratory and digestive system, diseases of skin and tissue, nutritional, accidents, poisoning, violence, ear diseases, infective and parasitic diseases, complications of pregnancy, child birth and mental disorders.

The Kyle service area is approximately 35 x 35 miles long and includes the communities of Potato Creek, Rockyford, Porcupine, Allen and Sharps Corner. This area is part of Shannon, Bennett and Jackson counties in South Dakota.

Mr. Chairman, we of the Medicine Root district and Kyle community have been working with the Indian Health Service to help alleviate these health problems. We both recognize the need for a replacement health facility. Efforts between the Oglala Sioux Tribe and the Indian Health Service have resulted in a mutual planning effort. This effort to date has accomplished a Program Information Document for a replacement Health Center.

The Kyle Health Center facility will be the location of curative and preventive health care programs. The proposed facility has been planned in order to meet the health needs of the Medicine Root district and Kyle community on the Pine Ridge reservation which will provide a full range of outpatient and speciality clinics. Outpatient services will include diagnostic and treatment services including limited emergency treatment. Health services such as; family planning, well-baby, otitis media, mental health, optometry, alcohol and drug abuse and nutrition counseling. Preventive health services will be offered which will include; public health nursing, social service, mental health, health education and community environmental health programs.

In our planning efforts with the Indian Health Service, the Program Information Document calls for an estimated 17,839 gross square feet and will service a projected population of 4,111 in 1989. The planning assumptions in the document reflect current medical and professional philosophies as well as current professional and accreditation standards established by numerous professional organizations and agencies. The Kyle health facility is planned in accordance with the Health Facility Planning Manual Vol. I Indian Health Service. The Indian Health Service, the Denver Regional Office of Engineering and Oglala Sioux Tribal council are fully in support of the Program Information Document.

Presently we are number one on the IHS priority system list for a replacement health center facility. As a result of being on the priority system list, the Oglala Sioux Tribe and the Medicine Root district and Kyle Community have set aside Tribal land in the amount of twenty (20) acres. The Denver Regional Office has already completed a site survey.

Mr. Chairman, Honored members of the Committee, we in the Kyle community are here today to respectfully request funding for a replacement health center which we desperately need. We have been very careful in our planning estimates and as you can see we have been diligently working with the Indian Health Service and the Denver Regional Office of Engineering. The amount that we need for design, development and construction for a replacement health facility is \$3,480,000. An additional \$2,625,000 is also needed for staff housing. Your utmost consideration for this funding will certainly be appreciated by the Oglala Sioux people of the Kyle Service area. I want to thank each one of you for allowing me to provide this testimony today. Thank you.



Oneida bringing several hundred bags of corn to Washington's starving army at Valley Forge, after the soldiers had completely refused to eat them.

ONEIDA COMMUNITY HEALTH CENTER

P.O. BOX 365
ONEIDA, WISCONSIN 54155



GEORGE BROWN FETTER
Member of the tribe of the Oneida Chief to accompany a friend ship between the nations and the College of Pennsylvania, a representative, the United States and Oneida people.

ONEIDA-3711

TO: Patricia Zell
Senate Committee on Indian Affairs

FROM: Barbara Hill Hawkins, Administrator
Marjorie Stevens, Coordinator of Chemical Dependency

DATE: June 21, 1983

RE: Indian Health Care Improvement Act

Statistically across the country alcoholism has reached epidemic proportions. Whereas Oneida may not statistically fit in with the American (i.e., white middle-class) dream, this community shares the unfortunate statistic of alcoholism. The definition of alcoholism developed by the National Council on Alcoholism, the American Medical Association and the Alcoholism Committee state: Alcoholism is a chronic, progressive, and potentially fatal disease. It is characterized by: tolerance, physical dependency and/or pathological organ changes all of which are the direct or indirect consequence of the alcohol ingested. Therefore there are physical, emotional and social changes in the individual suffering from the disease of alcoholism. Alcoholism is a disease and not a moral issue of a person with the preceding, it is evident The Oneida Community is inflicted with a disease of epidemic proportions.

Duties currently performed by present staff include 1) individual counseling, 2) group counseling, 3) family counseling, 4) client intake, 5) client orientation, 6) client education, 7) client motivation, 8) treatment planning, 9) consultation, 10) referral, 11) case management, 12) utilization, 13) reports and record-keeping, 14) client follow-up, 15) client aftercare, 16) crisis intervention, 17) community outreach, 18) prevention and 19) intervention.

In 1978, 95% of the Oneida Community stated alcohol is a problem. If the Chemical Dependency Department is allowed to close, Outagamie and Brown County will have to pickup and provide those services to the Oneida people. This will, of course, mean the people will have to go to either Appleton, or Green Bay for the services available here. The problems of transportation are obvious. However, the problem is greater than that. Alcoholism is not the isolated individual moral problem it was once portrayed as. Instead, alcoholism is a personal, a family and a

Oneida Tribe of Indians of Wisconsin

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community illness, therefore it must be dealt with on all three levels here to be successful.

Furthermore, it is important national leaders pledge their support to combat this illness.

Therefore, ^{we} highly endorse the reauthorization of the Indian Health Care Improvement Act in order to continue to address these vital concerns to Indian People.

:tf

PREPARED STATEMENT OF DEBRA R. WILSON, ASSISTANT
COLLEGE COORDINATOR/PRE-PROFESSIONAL STUDENTS,
INMED PROGRAM

Honorable Senator Mark Andrews:

I am a life long resident of North Dakota and a member of the Three Affiliated Tribes, Fort Berthold Agency. I am presently employed as the Assistant College Coordinator/Pre-Professional Students for the Indians Into Medicine (INMED) Program at the University of North Dakota in Grand Forks.

There is a tremendous need for trained American Indian medical personnel to work with Indian people. We are just beginning to reap the benefits of college and university programs that provide the personal support and financial resources that enable our young people to enter critical need areas of medicine. These young people will provide inestimable services to American Indians in places where other doctors, nurses, technicians, etc., too often choose not to go.

The non-attendance and dropout rate in higher education amongst American Indians is well-known. Our students overcome tremendous odds of limited preparation in math and science; lack of experience in competitive academics; minimal access to environmental learning support, i.e. libraries; undeveloped communication skills; and feelings of alienation and loneliness.

Programs, such as INMED, provide essential support in tutoring; academic and personal counseling; system knowledge; supplementary financial resource information; linkage with other University departments and other Universities across the country; and a home away from home for Indian students at all levels in the University setting.

Presently (1983), our program can only provide two years of services under Public Law 94-437 Pregraduate Section 103 to beginning students. Previously the regulations allowed full four year support. If our students are to successfully complete their undergraduate program and compete for highly selective openings in medical schools and other health professions, we must have the resources to assist them. We ask your assistance in generating more support for a comprehensive four or five year undergraduate scholarship for INMED students.

Our present students also have a need for more financial support for themselves and their families. Each student regardless of family size, receives a monthly stipend of \$555.00. This amount may be adequate for single students but places too many of our students with children below poverty level. The cost of living continues to rise and our students struggle to meet basic survival needs of housing, food, and clothing. Many of them must pay for medical insurance, dental care, and babysitting from their living stipend. It is not enough. Such financial exigency is detrimental to academic success. We ask for your assistance in obtaining more equitable living resources for our INMED students.

I would like to thank the Senate Select Committee, and you personally for your past support of the INMED Program. Your further support is urgently needed for our present and future INMED students, if they are to become the needed health and medical professionals so needed in Indian communities across the country.

Thank you,

Debra R. Wilson

Debra R. Wilson